Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN

March 16, 2013

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

RHP Lead Contact: Beth Cloyd
2525 Holly Hall / Houston, TX 77054
(713) 566-6405
beth.cloyd@harrishealth.org

Additional Contact: Nicole Lievsay
(713) 566-6817
Section I. RHP Organization
Section I. RHP Organization

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

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

<table>
<thead>
<tr>
<th>RHP Participant Type</th>
<th>Texas Provider Identifier (TPI)</th>
<th>Texas Identification Number (TIN)</th>
<th>Ownership Type (state owned, non-state public, private)</th>
<th>Organization Name</th>
<th>Lead Representative</th>
<th>Lead Representative Contact Information (address, email, phone number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anchoring Entity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Hospital District</td>
<td>133355104</td>
<td>1741536936 6 324</td>
<td>Non-state public</td>
<td>Harris County Hospital District (Harris Health System)</td>
<td>Beth Cloyd</td>
<td>2525 Holly Hall, Houston, TX 77054 <a href="mailto:Beth.Cloyd@harrishealth.org">Beth.Cloyd@harrishealth.org</a> 713-566-6405</td>
</tr>
<tr>
<td>IGT Entities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Hospital</td>
<td>020993401</td>
<td>17601536299001</td>
<td>Non-state public</td>
<td>Bayside Community Hospital</td>
<td>Theresa Cheaney</td>
<td>P.O. Box 398, Anahuac, TX 77514 <a href="mailto:tcheaney@chambershealth.org">tcheaney@chambershealth.org</a> 409-267-3143</td>
</tr>
<tr>
<td>Public Hospital District</td>
<td>083290905</td>
<td>1-76-0636528-0-000</td>
<td>Non-state public</td>
<td>Bellville Hospital District</td>
<td>Michael Morris</td>
<td>44 N. Cummings Bellville TX 77418 <a href="mailto:mmorris@bellvillehospital.com">mmorris@bellvillehospital.com</a> 979-413-7400</td>
</tr>
<tr>
<td>Public Hospital</td>
<td>131045004</td>
<td>1760488120 5 000</td>
<td>Non-state public</td>
<td>El Campo Memorial Hospital</td>
<td>Tisha Zalman</td>
<td>303 Sandy Corner Rd, El Campo, TX 77437 <a href="mailto:tzalman@ecmh.org">tzalman@ecmh.org</a> 979-543-6251</td>
</tr>
<tr>
<td>Public Hospital District / Safety Net Hospital</td>
<td>133355104</td>
<td>1741536936 6 324</td>
<td>Non-state public</td>
<td>Harris County Hospital District / Ben Taub</td>
<td>Nicole Lievsay</td>
<td>2525 Holly Hall Drive, Houston, TX 77054 <a href="mailto:Nicole.lievsay@harrishealth.org">Nicole.lievsay@harrishealth.org</a> 713-566-6400</td>
</tr>
<tr>
<td>RHP Participant Type</td>
<td>Texas Provider Identifier (TPI)</td>
<td>Texas Identification Number (TIN)</td>
<td>Ownership Type (state owned, non-state public, private)</td>
<td>Organization Name</td>
<td>Lead Representative</td>
<td>Lead Representative Contact Information (address, email, phone number)</td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------------------------------</td>
<td>-----------------------------------</td>
<td>--------------------------------------------------------</td>
<td>-------------------</td>
<td>---------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>General Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Hospital</td>
<td>130959304</td>
<td>17460250693001</td>
<td>Non-state public</td>
<td>Matagorda Regional Medical Center</td>
<td>Steve Smith</td>
<td>104 7th Street, Bay City, TX 77414 <a href="mailto:ssmith@matagordaregional.org">ssmith@matagordaregional.org</a> 979-241-5520</td>
</tr>
<tr>
<td>Public Hospital</td>
<td>137909111</td>
<td>17460034113000</td>
<td>Non-state public</td>
<td>Memorial Medical Center</td>
<td>Jason Anglin</td>
<td>815 N. Virginia Street Port Lavaca, Texas 77979 <a href="mailto:janglin@mmcpportlavaca.com">janglin@mmcpportlavaca.com</a> 361-552-0222</td>
</tr>
<tr>
<td>Public Hospital</td>
<td>127303903</td>
<td>1760339462 2000</td>
<td>Non-state public</td>
<td>Oakbend Medical Center</td>
<td>Darren Coates</td>
<td>2801 Via Fortuna, Suite 500 Austin, 78746 <a href="mailto:coates@gl-law.com">coates@gl-law.com</a> 512-899-3995</td>
</tr>
<tr>
<td>Public Hospital District</td>
<td>NA</td>
<td>1760487947 2002</td>
<td>Non-state public</td>
<td>Rice Hospital District</td>
<td>Vicki Powers</td>
<td>600 S Austin Rd, Eagle Lake, TX 77434 <a href="mailto:vlpowers@hotmail.com">vlpowers@hotmail.com</a> (979) 234-5571</td>
</tr>
<tr>
<td>Public Hospital District</td>
<td>NA</td>
<td>NA</td>
<td>Non-state public</td>
<td>Tomball Regional Hospital Auth</td>
<td>Jerald Till</td>
<td>13302 Wildwood Drive Tomball, Texas 77375 <a href="mailto:jerry.15260@yahoo.com">jerry.15260@yahoo.com</a> (281) 351-8514</td>
</tr>
<tr>
<td>State Hospital</td>
<td>112672402</td>
<td>1-746001118-6005</td>
<td>State Owned</td>
<td>The University of Texas M.D. Anderson Cancer Center</td>
<td>Lewis Foxhall, MD</td>
<td>Office of Health Policy 1515 Holcombe Boulevard, Unit 1487 Houston, TX 77030-4009 <a href="mailto:lfoxhall@mdanderson.org">lfoxhall@mdanderson.org</a></td>
</tr>
<tr>
<td>County Health Dept</td>
<td>2967606-01</td>
<td>17460019692031</td>
<td>Non-state public</td>
<td>Fort Bend County Health Dept</td>
<td>Mary Desvignes-Kendrick</td>
<td>4520 Reading Road, Suite A-100, Rosenberg, TX 77471 <a href="mailto:md.kendrick@co.fort-bend.tx.us">md.kendrick@co.fort-bend.tx.us</a> 281-238-3589</td>
</tr>
<tr>
<td>County Health Dept</td>
<td>NA</td>
<td>17604545149159</td>
<td>Non-state public</td>
<td>Harris County Public Health &amp; Environmental Svcs</td>
<td>Herminia Palacio, MD</td>
<td>2223 West Loop South, Houston, Texas 77027 <a href="mailto:hpalacio@hcphes.org">hpalacio@hcphes.org</a> 713-439-6016</td>
</tr>
<tr>
<td>City Health Dept</td>
<td>0937740-08,-03,-07</td>
<td>17460011640002</td>
<td>Non-state public</td>
<td>Houston Dept of Health &amp; Human Svcs</td>
<td>Judy Harris</td>
<td>8000 N. Stadium Dr. Houston, TX 77054 <a href="mailto:Judy.Harris@houstontx.gov">Judy.Harris@houstontx.gov</a> 832-393-4345</td>
</tr>
<tr>
<td>RHP Participant Type</td>
<td>Texas Provider Identifier (TPI)</td>
<td>Texas Identification Number (TIN)</td>
<td>Ownership Type (state owned, non-state public, private)</td>
<td>Organization Name</td>
<td>Lead Representative</td>
<td>Lead Representative Contact Information (address, email, phone number)</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------</td>
<td>----------------------------------</td>
<td>------------------------------------------------</td>
<td>------------------</td>
<td>---------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Academic Organization</td>
<td>082006001</td>
<td>17416138786000</td>
<td>Private</td>
<td>Baylor College of Medicine *Higher Education Coordinating Board Agreement</td>
<td>Lorie Tabak</td>
<td>One Baylor Plaza MS BCM109, Houston, TX 77030 <a href="mailto:tabak@bcm.edu">tabak@bcm.edu</a> 713-798-6649</td>
</tr>
<tr>
<td>Academic Organization</td>
<td>112672402</td>
<td>1-746001118-6005</td>
<td>State Owned</td>
<td>The University of Texas M.D. Anderson Cancer Center</td>
<td>Lewis Foxhall, MD</td>
<td>Office of Health Policy 1515 Holcombe Boulevard, Unit 1487 Houston, TX 77030-4009 <a href="mailto:lfoxhall@mdanderson.org">lfoxhall@mdanderson.org</a></td>
</tr>
<tr>
<td>Academic Organization</td>
<td>111810101</td>
<td>17604595003002</td>
<td>Non-state public</td>
<td>University of Texas Health Science Center</td>
<td>Andrew Casas</td>
<td>6410 Fannin STE 1500 Houston Texas 77030 <a href="mailto:Andrew.Casas@uth.tmc.edu">Andrew.Casas@uth.tmc.edu</a> 832-325-7325</td>
</tr>
<tr>
<td>Local Mental Health Authority</td>
<td>135254407</td>
<td>1 74 165 9064 8 004</td>
<td>Non-state public</td>
<td>GulfBend Center</td>
<td>Donald L. Polzin</td>
<td>6502 Nursery Drive, Ste 100, Victoria, TX 77904 <a href="mailto:dpolzin@gulfbend.org">dpolzin@gulfbend.org</a> 361-582-2314</td>
</tr>
<tr>
<td>Local Mental Health Authority</td>
<td>113180703</td>
<td>7416039505023</td>
<td>Non-state public</td>
<td>Mental Health – Mental Retardation Authority</td>
<td>Dr. Scott Strang</td>
<td>7011 Southwest Fwy, Houston, TX 77074 <a href="mailto:scott.strang@mhmraharris.org">scott.strang@mhmraharris.org</a> 713-970-7182</td>
</tr>
<tr>
<td>Local Mental Health Authority</td>
<td>096166602</td>
<td>17416841983003</td>
<td>Non-state public</td>
<td>Spindletop Center</td>
<td>Chalonnes Hoover</td>
<td>P.O. Box 3846, Beaumont TX 77704-3846 <a href="mailto:chalonnes.hoover@stctr.org">chalonnes.hoover@stctr.org</a> 409-784-5668</td>
</tr>
<tr>
<td>Local Mental Health Authority</td>
<td>081522701</td>
<td>17602532875007</td>
<td>Non-state public</td>
<td>Texana</td>
<td>Amanda Darr</td>
<td>4910 Airport Avenue, Building D, Rosenberg, TX 77471 <a href="mailto:amanda.darr@texanacenter.com">amanda.darr@texanacenter.com</a> 281-239-1350</td>
</tr>
<tr>
<td>Performing Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic Organization</td>
<td>082006001</td>
<td>17416138786000</td>
<td>Private</td>
<td>Baylor College of Medicine</td>
<td>Lorie Tabak</td>
<td>One Baylor Plaza MS BCM109, Houston, TX 77030 <a href="mailto:tabak@bcm.edu">tabak@bcm.edu</a> 713-798-6649</td>
</tr>
<tr>
<td>RHP Participant Type</td>
<td>Texas Provider Identifier (TPI)</td>
<td>Texas Identification Number (TIN)</td>
<td>Ownership Type (state owned, non-state public, private)</td>
<td>Organization Name</td>
<td>Lead Representative</td>
<td>Lead Representative Contact Information (address, email, phone number)</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------</td>
<td>-----------------------------------</td>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------</td>
<td>--------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>135033204</td>
<td>1741394418 6 005</td>
<td>Private</td>
<td>Columbus Community Hospital</td>
<td>Rob Thomas</td>
<td>110 Shult Drive, Columbus, TX 78934 <a href="mailto:rthomas@columbusch.com">rthomas@columbusch.com</a> 979-732-2371</td>
</tr>
<tr>
<td>Public Hospital</td>
<td>131045004</td>
<td>1760488120 5 000</td>
<td>Non-state public</td>
<td>El Campo Memorial Hospital</td>
<td>Tisha Zalman</td>
<td>303 Sandy Corner Rd, El Campo, TX 77437 <a href="mailto:tzalman@ecmh.org">tzalman@ecmh.org</a> 979-543-6251</td>
</tr>
<tr>
<td>County Health Dept</td>
<td>2967606-01</td>
<td>17460019692031</td>
<td>Non-state public</td>
<td>Fort Bend County Health Dept</td>
<td>Mary Desvignes-Kendrick</td>
<td>4520 Reading Road, Suite A-100, Rosenberg, TX 77471 <a href="mailto:md.kendrick@co.fort-bend.tx.us">md.kendrick@co.fort-bend.tx.us</a> 281-238-3589</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>178815001</td>
<td>1203745677 4 003</td>
<td>Private</td>
<td>Gulf Coast Medical Center</td>
<td>Randy Slack</td>
<td>10141 US 59 RD Wharton, Texas <a href="mailto:randy.sack@gulfcoastmedical.com">randy.sack@gulfcoastmedical.com</a> 979-282-6100</td>
</tr>
<tr>
<td>Public Hospital District</td>
<td>133355104</td>
<td>1741536936 6 324</td>
<td>Non-state public</td>
<td>Harris County Hospital District / Ben Taub General Hospital</td>
<td>Nicole Lievsay</td>
<td>2525 Holly Hall Drive, Houston, TX 77054 <a href="mailto:Nicole.lievsay@harrishealth.org">Nicole.lievsay@harrishealth.org</a> 713-566-6400</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>020817501</td>
<td>16218013593000</td>
<td>Private</td>
<td>HCA Gulf Coast Division – Bayshore Hospital</td>
<td>Jeff Sliwinski</td>
<td>7400 Fannin St, Ste 650, Houston, TX 77054 <a href="mailto:Jeff.Sliwinski@HCAHealthcare.com">Jeff.Sliwinski@HCAHealthcare.com</a> 713-852-1534</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>094187402</td>
<td>16218013635005</td>
<td>Private</td>
<td>HCA Gulf Coast Division – West Houston Medical Center</td>
<td>Jeff Sliwinski</td>
<td>7400 Fannin St, Ste 650, Houston, TX 77054 <a href="mailto:Jeff.Sliwinski@HCAHealthcare.com">Jeff.Sliwinski@HCAHealthcare.com</a> 713-852-1534</td>
</tr>
<tr>
<td>City Health Dept</td>
<td>0937740-08,-03,-07</td>
<td>17460011640002</td>
<td>Non-state public</td>
<td>Houston Dept of Health &amp; Human Svcs</td>
<td>Judy Harris</td>
<td>8000 N. Stadium Dr. Houston, TX 77054 <a href="mailto:Judy.Harris@houstontx.gov">Judy.Harris@houstontx.gov</a> 832-393-4345</td>
</tr>
<tr>
<td>Public Hospital</td>
<td>130959304</td>
<td>17460250693001</td>
<td>Non-state public</td>
<td>Matagorda Regional Medical Center</td>
<td>Steve Smith</td>
<td>104 7th Street, Bay City, TX 77414 <a href="mailto:ssmith@matagordaregional.org">ssmith@matagordaregional.org</a> 979-241-5520</td>
</tr>
<tr>
<td>Private Hospital / Safety Net Hospital</td>
<td>137805107</td>
<td>17411525979 064</td>
<td>Private</td>
<td>Memorial Hermann Healthcare System</td>
<td>Jeff Brownawell</td>
<td>929 Gessner, Ste 2700, Houston, TX 77024 <a href="mailto:Jeffrey.brownawell@memorialhermann.org">Jeffrey.brownawell@memorialhermann.org</a> 713-242-2785</td>
</tr>
<tr>
<td>RHP Participant Type</td>
<td>Texas Provider Identifier (TPI)</td>
<td>Texas Identification Number (TIN)</td>
<td>Ownership Type (state owned, non-state public, private)</td>
<td>Organization Name</td>
<td>Lead Representative</td>
<td>Lead Representative Contact Information (address, email, phone number)</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---------------------------------</td>
<td>-----------------------------------</td>
<td>---------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>146509801</td>
<td>17411525979 058</td>
<td>Private</td>
<td>Memorial Hermann Healthcare System - Katy</td>
<td>Jeff Brownawell</td>
<td>929 Gessner, Ste 2700, Houston, TX 77024 <a href="mailto:Jeffrey.brownawell@memorialhermann.org">Jeffrey.brownawell@memorialhermann.org</a> 713-242-2785</td>
</tr>
<tr>
<td>Private Hospital / Safety Net Hospital</td>
<td>192751901</td>
<td>17411525979 044</td>
<td>Private</td>
<td>Memorial Hermann Healthcare System - Northeast</td>
<td>Jeff Brownawell</td>
<td>929 Gessner, Ste 2700, Houston, TX 77024 <a href="mailto:Jeffrey.brownawell@memorialhermann.org">Jeffrey.brownawell@memorialhermann.org</a> 713-242-2785</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>146021401</td>
<td>17411525979 036</td>
<td>Private</td>
<td>Memorial Hermann Healthcare System - Sugarland</td>
<td>Jeff Brownawell</td>
<td>929 Gessner, Ste 2700, Houston, TX 77024 <a href="mailto:Jeffrey.brownawell@memorialhermann.org">Jeffrey.brownawell@memorialhermann.org</a> 713-242-2785</td>
</tr>
<tr>
<td>State Hospital</td>
<td>112672402</td>
<td>1-746001118-6005</td>
<td>State Owned</td>
<td>The University of Texas M.D. Anderson Cancer Center</td>
<td>Lewis Foxhall, MD</td>
<td>Office of Health Policy 1515 Holcombe Boulevard, Unit 1487 Houston, TX 77030-4009 <a href="mailto:lfoxhall@mdanderson.org">lfoxhall@mdanderson.org</a></td>
</tr>
<tr>
<td>Private Hospital</td>
<td>146509801</td>
<td>17411525979 501</td>
<td>Private</td>
<td>Memorial Hermann Healthcare System – MHS (4-plex)</td>
<td>Jeff Brownawell</td>
<td>929 Gessner, Ste 2700, Houston, TX 77024 <a href="mailto:Jeffrey.brownawell@memorialhermann.org">Jeffrey.brownawell@memorialhermann.org</a> 713-242-2785</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>146509801</td>
<td>17411525979 061</td>
<td>Private</td>
<td>Memorial Hermann Healthcare System – Memorial City</td>
<td>Jeff Brownawell</td>
<td>929 Gessner, Ste 2700, Houston, TX 77024 <a href="mailto:Jeffrey.brownawell@memorialhermann.org">Jeffrey.brownawell@memorialhermann.org</a> 713-242-2785</td>
</tr>
<tr>
<td>Public Hospital</td>
<td>137909111</td>
<td>17460034113000</td>
<td>Non-state public</td>
<td>Memorial Medical Center</td>
<td>Jason Anglin</td>
<td>815 N. Virginia Street Port Lavaca, Texas 77979 <a href="mailto:janglin@mmcportlavaca.com">janglin@mmcportlavaca.com</a> 361-552-0222</td>
</tr>
<tr>
<td>Local Mental Health Authority</td>
<td>113180703</td>
<td>17416039505023</td>
<td>Non-state public</td>
<td>Mental Health – Mental Retardation</td>
<td>Dr. Scott Strang</td>
<td>7011 Southwest Fwy, Houston, TX 77074 <a href="mailto:scott.strang@mhmraharris.org">scott.strang@mhmraharris.org</a> 713-970-7182</td>
</tr>
<tr>
<td>RHP Participant Type</td>
<td>Texas Provider Identifier (TPI)</td>
<td>Texas Identification Number (TIN)</td>
<td>Ownership Type (state owned, non-state public, private)</td>
<td>Organization Name</td>
<td>Lead Representative</td>
<td>Lead Representative Contact Information (address, email, phone number)</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------</td>
<td>----------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------</td>
<td>---------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Public Hospital</td>
<td>127303903</td>
<td>1760339462 2 000</td>
<td>Non-state public</td>
<td>Oakbend Medical Center</td>
<td>Darren Coates</td>
<td>2801 Via Fortuna, Suite 500 Austin, 78746 <a href="mailto:coates@gl-law.com">coates@gl-law.com</a> 512-899-3995</td>
</tr>
<tr>
<td>Public Hospital</td>
<td>212060201</td>
<td>1270565499 9 000</td>
<td>Non-state public</td>
<td>Rice Medical Center</td>
<td>Jim Janek</td>
<td>600 S Austin Rd, Eagle Lake, TX 77434 <a href="mailto:jjanek@ricemedicalcenter.net">jjanek@ricemedicalcenter.net</a> (979) 234-5571</td>
</tr>
<tr>
<td>Local Mental Health Authority</td>
<td>096166602</td>
<td>17416841983003</td>
<td>Non-state public</td>
<td>Spindletop Center</td>
<td>Chalonnnes Hoover</td>
<td>P.O. Box 3846, Beaumont TX 77704-3846 <a href="mailto:chalonnnes.hoover@stctr.org">chalonnnes.hoover@stctr.org</a> 409-784-5668</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>181706601</td>
<td>12048355783003</td>
<td>Private</td>
<td>St. Joseph’s Medical Center</td>
<td>Patrick Matthews</td>
<td>1401 St Joseph Parkway Houston, TX 77002 <a href="mailto:Patrick.Matthews@sjmctx.com">Patrick.Matthews@sjmctx.com</a> 713-756-5298</td>
</tr>
<tr>
<td>Local Mental Health Authority</td>
<td>081522701</td>
<td>17602532875007</td>
<td>Non-state public</td>
<td>Texana</td>
<td>Amanda Darr</td>
<td>4910 Airport Avenue, Building D, Rosenberg, TX 77471 <a href="mailto:amanda.darr@texanacenter.com">amanda.darr@texanacenter.com</a> 281-239-1350</td>
</tr>
<tr>
<td>Children’s Hospital / Safety Net</td>
<td>139135109</td>
<td>17411005550501</td>
<td>Private</td>
<td>Texas Children’s Hospital</td>
<td>Alec King</td>
<td>6621 Fannin, Ste A135, Houston, TX 77030 <a href="mailto:ahking@texaschildrens.org">ahking@texaschildrens.org</a> 832-824-2946</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>140713201</td>
<td>1741180155 2 018</td>
<td>Private</td>
<td>The Methodist Hospital</td>
<td>Carolyn Belk</td>
<td>1707 Sunset Blvd., Houston, TX, 77005 <a href="mailto:cbelk@tmhs.org">cbelk@tmhs.org</a> 832-667-5883</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>140713201</td>
<td>1741287015 0 002</td>
<td>Private</td>
<td>The Methodist Hospital – San Jacinto</td>
<td>Carolyn Belk</td>
<td>1707 Sunset Blvd., Houston, TX, 77005 <a href="mailto:cbelk@tmhs.org">cbelk@tmhs.org</a> 832-667-5883</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>140713201</td>
<td>1760545192 5 001</td>
<td>Private</td>
<td>The Methodist Hospital - Willowbrook</td>
<td>Carolyn Belk</td>
<td>1707 Sunset Blvd., Houston, TX, 77005 <a href="mailto:cbelk@tmhs.org">cbelk@tmhs.org</a> 832-667-5883</td>
</tr>
<tr>
<td>RHP Participant Type</td>
<td>Texas Provider Identifier (TPI)</td>
<td>Texas Identification Number (TIN)</td>
<td>Ownership Type (state owned, non-state public, private)</td>
<td>Organization Name</td>
<td>Lead Representative</td>
<td>Lead Representative Contact Information (address, email, phone number)</td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------------------------------</td>
<td>-----------------------------------</td>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>-----------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>288523801</td>
<td>32044775339001</td>
<td>Private</td>
<td>Tomball Regional Medical Center</td>
<td>Richard Ervin</td>
<td>605 Holderrieth Blvd, Tomball, TX 77375 <a href="mailto:RErvin@tomballhospital.org">RErvin@tomballhospital.org</a> 281-401-7897</td>
</tr>
<tr>
<td>Academic Organization</td>
<td>111810101</td>
<td>17604595003002</td>
<td>Non-state public</td>
<td>University of Texas Health Science Center</td>
<td>Andrew Casas</td>
<td>6410 Fannin STE 1500 Houston Texas 77030 <a href="mailto:Andrew.Casas@uth.tmc.edu">Andrew.Casas@uth.tmc.edu</a> 832-325-7325</td>
</tr>
<tr>
<td>Academic Organization</td>
<td>112672402</td>
<td>1-746001118-6005</td>
<td>State Owned</td>
<td>The University of Texas M.D. Anderson Cancer Center</td>
<td>Lewis Foxhall, MD</td>
<td>Office of Health Policy 1515 Holcombe Boulevard, Unit 1487 Houston, TX 77030-4009 <a href="mailto:lfoxhall@mdanderson.org">lfoxhall@mdanderson.org</a></td>
</tr>
<tr>
<td>UC-only Hospitals (list hospitals that will only be participating in UC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Hospital</td>
<td>020993401</td>
<td>17601536299001</td>
<td>Non-state public</td>
<td>Bayside Community Hospital</td>
<td>Theresa Cheaney</td>
<td>P.O. Box 398, Anahuac, TX 77514 <a href="mailto:tcheaney@chambershealth.org">tcheaney@chambershealth.org</a> 409-267-3143</td>
</tr>
<tr>
<td>Public Hospital</td>
<td>083290905</td>
<td>127 4005511 1 000</td>
<td>Non-state public</td>
<td>Bellville General Hospital</td>
<td>Michael Morris</td>
<td>44 N. Cummings Bellville TX 77418 <a href="mailto:mmorris@bellvillehospital.com">mmorris@bellvillehospital.com</a> 979-413-7400</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>094225202</td>
<td>17605915929003</td>
<td>Private</td>
<td>Christus St. Catherine Hospital</td>
<td>Mike Sullivan</td>
<td>18300 St. John Drive Nassau Bay, TX 77058 <a href="mailto:mike.sullivan@christushealth.org">mike.sullivan@christushealth.org</a> 281.336.3722</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>094198102</td>
<td>17605915929003</td>
<td>Private</td>
<td>Christus St. John Hospital</td>
<td>Mike Sullivan</td>
<td>18300 St. John Drive Nassau Bay, TX 77058 <a href="mailto:mike.sullivan@christushealth.org">mike.sullivan@christushealth.org</a> 281.336.3722</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>152686501</td>
<td>760698013</td>
<td>Private</td>
<td>Palacios Community Medical Center</td>
<td>Don Bates</td>
<td>311 Green Ave, Palacios, TX 77465 <a href="mailto:dbpeme@tisd.net">dbpeme@tisd.net</a> 361-972-2514</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>148698701</td>
<td>17529229282 000</td>
<td>Private</td>
<td>Winnie Community</td>
<td>Albert B. Schwarzer</td>
<td>3221 Collinsworth, Ste 200 Fort Worth, TX 76107</td>
</tr>
<tr>
<td>RHP Participant Type</td>
<td>Texas Provider Identifier (TPI)</td>
<td>Texas Identification Number (TIN)</td>
<td>Ownership Type (state owned, non-state public, private)</td>
<td>Organization Name</td>
<td>Lead Representative</td>
<td>Lead Representative Contact Information (address, email, phone number)</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------</td>
<td>----------------------------------</td>
<td>------------------------------------------------------------</td>
<td>-------------------</td>
<td>--------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hospital</td>
<td></td>
<td></td>
<td><a href="mailto:albert@frontierhealthcare.com">albert@frontierhealthcare.com</a> 817-731-1997</td>
</tr>
</tbody>
</table>

Other Stakeholders (specify type)

<table>
<thead>
<tr>
<th>County Health Dept</th>
<th></th>
<th></th>
<th>Harris County Public Health &amp; Environmental Svcs</th>
<th>Herminia Palacio, MD</th>
<th>2223 West Loop South, Houston, Texas 77027</th>
<th><a href="mailto:hpalacio@hcpphs.org">hpalacio@hcpphs.org</a> 713-439-6016</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Medical Associations/Societies</td>
<td></td>
<td></td>
<td>Harris County Medical Society</td>
<td>Keith Bourgeois, MD</td>
<td>1515 Hermann Drive, Houston, TX 77004</td>
<td>713-524-4267</td>
</tr>
<tr>
<td>Other significant safety net providers within the region (specify type)</td>
<td>SETRAC</td>
<td></td>
<td>SETRAC</td>
<td>Darrell Pile</td>
<td>1111 North Loop West, Ste 160, Houston, TX 77008</td>
<td><a href="mailto:Darrell.pile@setrac.org">Darrell.pile@setrac.org</a> 281-822-4444</td>
</tr>
<tr>
<td>Others (specify type, e.g. advocacy groups, associations)</td>
<td>Gateway to Care</td>
<td></td>
<td>Gateway to Care</td>
<td>Ron Cookston</td>
<td>3611 Ennis; Houston, TX 77004</td>
<td><a href="mailto:ron.cookston@gatewaytocare.org">ron.cookston@gatewaytocare.org</a> 713-783-4616</td>
</tr>
<tr>
<td></td>
<td>Greater Houston Partnership</td>
<td></td>
<td>Greater Houston Partnership</td>
<td>Mark Wallace</td>
<td>6621 Fannin Street, A135, MC 1-4460</td>
<td><a href="mailto:mawallac@texaschildrens.org">mawallac@texaschildrens.org</a> 832-824-1160</td>
</tr>
<tr>
<td></td>
<td>Houston- Galveston Area Council</td>
<td></td>
<td>Houston- Galveston Area Council</td>
<td>Mary E. Koch</td>
<td>P.O. Box 22777, Houston, TX 77227</td>
<td><a href="mailto:Mary.Koch@wrksolutions.com">Mary.Koch@wrksolutions.com</a> 713-627-3200</td>
</tr>
<tr>
<td></td>
<td>Partners for Community Health</td>
<td></td>
<td>Partners for Community Health</td>
<td>John Kajander</td>
<td>1310 Prairie St. Suite 1080, Houston TX 77002</td>
<td><a href="mailto:jkajander@hctx.net">jkajander@hctx.net</a> 713-368-1340</td>
</tr>
</tbody>
</table>
Section II. Executive Overview of RHP Plan
Section II. Executive Overview of RHP Plan

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

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

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

- Inadequate primary care and specialty care capacity to meet the demands of a large and continually growing population. Every county in the region is designated a Health Professional Shortage Area for primary care, behavioral health care and dental care. Patients experience long waits for appointments and often turn to emergency rooms for primary care and non-urgent health care services that do not require emergency services.
- High prevalence of chronic disease, including diabetes, obesity, cancer, asthma and heart disease;
- High prevalence of unhealthy lifestyle behaviors, including smoking, substance abuse, lack of exercise, and poor nutritional habits;
- A diverse population that includes a large number of immigrants that speak more than a dozen different languages requiring language interpretation services and culturally-appropriate care;
- Insufficient transportation services that delay patients’ access to care and encourages inappropriate utilization of emergency services;
- High utilization of emergency services for non-urgent, episodic care;
- Lack of coordination among primary and specialty care providers, and fragmentation of inpatient, outpatient and ancillary services.
- Lack of patient training and education programs that encourage and enable consumers to take charge of their health, and
- Absence of a regional plan for facilitating shared-training and learning programs among providers, with a focus on sharing best-practices and lessons learned.
The need for services and the health care challenges we face as a community are admirably addressed by the existing health care providers, but the sheer volume of need is overwhelming and often frustrating for the dedicated professionals who work in our Region. Health care services are provided by more than 12,250 physicians representing more than 200 specialties, and 85 acute care hospitals.\(^1\) With a total of more than 13,000 inpatient beds, hospital services provided in 2010 included more than 1.6 million emergency room visits, 8.3 million outpatient visits, and more than 522,000 inpatient admissions.\(^2\) Our health care system includes the Texas Medical Center (TMC), an organization of 52 renowned medical research and academic institutions that provide cutting edge research and services. In 2010, these facilities collectively were responsible for 7.1 million patient visits, including 16,000 visits from international patients who travel from all over the world for life-saving treatment.

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

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

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

---

\(^1\) Texas Medical Board, Physician Demographics by County and Specialty, January 2012.
\(^2\) 2010 Cooperative Department of State Health Services/American Hospital Association/Texas Hospital Association Annual Survey of Hospitals and Hospitals Tracking Data Base.
\(^3\) U.S. Census Bureau, 2008-2010 American Community Survey 3 Year Estimates.
These goals provided the underlying principles that guided our discussions during the thousands of hours spent deliberating and developing our RHP projects. The inclusion of stakeholders in all stages of our work ensures that the project decisions are aimed at addressing the needs of our community and are informed by the first-hand knowledge of the providers, advocates, caregivers, and consumers who helped design our Plan. Because of their participation, we are confident that our projects will be successful in achieving our community goals. As a review of our projects and our community needs assessment will demonstrate, we have included projects specifically designed to improve access to all types of care, with a significant focus on expanding primary and behavioral health care services. Other Plan initiatives are targeted at improving the treatment of chronic disease; creation of medical homes and care coordination programs; integration of physical and behavioral health care services to treat the whole patient; consumer training and education programs that empower patients to take control of their own health; workforce recruitment and training programs that will expand the number of providers serving our region and maximize their ability to provide the most effective and cost-efficient care possible; and programs for expanding and enhancing the availability of services that meet the cultural diversity of our population. Initiatives are tailored to meet the unique needs of specific populations identified and will be specifically designed by local providers using best practices and proven strategies for improved patient outcomes. Our region will provide coordinated and ongoing training and support for all participants, with regular opportunities for stakeholder input to assess our progress.

Most importantly, our plan is a community-wide effort that includes partners who have a successful history of working together to improve the health of our population. The breadth and range of our projects will touch virtually every person accessing the health care system and will benefit patients for years to come. Improved access to care, increased patient satisfaction, reduction in costs, and better health care outcomes will affect not just the patients receiving care, but the entire community – employers who pay for health care, taxpayers who fund government health plans and purchase individual health coverage, and family members who serve as caregivers are all participating beneficiaries who will work together to ensure the successful implementation of our Plan.
<table>
<thead>
<tr>
<th>Pass</th>
<th>Category</th>
<th>Performing Provider</th>
<th>TPI</th>
<th>Project Unique ID Number</th>
<th>Project Title (include unique RHP project ID number for each project)</th>
<th>Brief Project Description</th>
<th>Related Category</th>
<th>Outcome Measure(s)</th>
<th>Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 &amp; 2 values)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Baylor College of Medicine</td>
<td>082006001</td>
<td>3.1</td>
<td>1.1.1 - Establish more primary care clinics: New Baylor TIRR Health Clinic at the Tejano Center for Community Concerns</td>
<td>The BTHC will establish a clinic at the Tejano Center for Community Concerns (TCCC) in the southeast part of the county to serve as the medical home for adolescents and young adults. By addressing the age-specific needs of the patient population, the BTHC will provide targeted, age-appropriate family planning and STI counseling and treatment in order to lower STI and teen birth rates.</td>
<td>IT-12.6-Other: Reduction of STI Rate among Adolescents and Young Adults</td>
<td>$2,334,000</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>Baylor College of Medicine</td>
<td>082006001</td>
<td>2.1</td>
<td>2.1.1 - Develop, implement, and evaluate action plans to minimize/eliminate gaps in the development of various aspects of PCMH standards: The Fifth Ward Model - Inter-professional Primary Care</td>
<td>The Fifth Ward Model Inter-Professional Primary Care Practice Demonstration Project will bring together an interdisciplinary team of healthcare professionals including physicians, mid-level providers (nurse practitioners and physicians’ assistants), nurses (RN, LPN), nursing assistants, clinical pharmacists (PharmD), social workers, health educators, and dental health professionals (psychologists, licensed professional counselors) to provide interdisciplinary primary healthcare to patients residing in a medically underserved community of Houston (the 5th ward).</td>
<td>IT-1.10: Improve HbA1c control P-1.20: Improve weight control</td>
<td>$5,131,300</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>City of Houston Department of Health and Human Services</td>
<td>0937740-08</td>
<td>1.3</td>
<td>1.8.11 The implementation of dental services for individuals in long-term care facilities, intermediate care facilities, and nursing homes, and to the elderly, and in those with special needs by enhancing dental workforce capacity through collaborations and partnerships with dental and dental hygiene schools, LHDs, FQHCs, and/or local dental providers</td>
<td>The Houston Health and Human Services (HHHHS) proposes to: a) provide ongoing diagnostic, preventive, restorative, and surgical oral health services for the low income at-risk elderly in the community; b) provide oral health services for previously screened elderly patients from Area Agency on Aging, Harris Health System, and area Federally Qualified Health Centers; and c) link more elderly to a dental home.</td>
<td>IT-7.8 Chronic Disease Patients Accessing Oral Health Services</td>
<td>$316,866</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>City of Houston Department of Health and Human Services</td>
<td>0937740-08</td>
<td>2.3</td>
<td>2.12.5 - Implement Shared Care Transitions Program, “Ohio” project option to reduce the incidence of hospital readmissions within 30 days of discharge for Medicare Fee For Service and Dual Eligible individuals that are hospitalized resulting from the chronic disease specifically, Congestive Heart Failure (CHF)</td>
<td>The performing provider, Houston Department of Health and Human Services (HHHHS) proposes to implement a program modeled after Colman Transitions Intervention to improve transitions of patients from the inpatient hospital setting to other care settings; to improve quality of care; to reduce avoidable readmissions for high-risk heart failure beneficiaries; and to document measurable savings to the Medicare program.</td>
<td>IT-5.2 Congestive Heart Failure 30 day readmission rate (National measures)</td>
<td>$4,451,417</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>City of Houston Department of Health and Human Services</td>
<td>0937740-08</td>
<td>2.9</td>
<td>2.19.2 - (Other) Develop Care Management Functions that integrate primary and behavioral health needs of individuals: Integrated Services for the Vulnerable</td>
<td>HHHHS proposes a comprehensive project to integrate evidence based and best practice models such as Housing First to reduce chronic homelessness and associated health and other public system costs.</td>
<td>IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction Scores</td>
<td>$2,498,709</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>City of Houston Department of Health and Human Services</td>
<td>0937740-08</td>
<td>2.8</td>
<td>2.7.1 - Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screening, colorectal cancer screening, prenatal alcohol use, etc.)</td>
<td>Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations- The Colorectal Cancer Awareness and Screening (3COAS) project</td>
<td>IT-9.4 Other Outcome Improvement Target</td>
<td>$10,911,392</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>City of Houston Department of Health and Human Services</td>
<td>0937740-08</td>
<td>1.2</td>
<td>2.7.7 - Implement remote patient monitoring programs for diagnosis and management of care for EMS services: Emergency Tele Health and Navigation (ETHAN)</td>
<td>The City of Houston proposes to make use of telecommunication technologies and connectivity to triage patients with non-life-threatening, mild or moderate illnesses, in telemedicine with an emergency physician at the City of Houston EMS base station. The physician will then determine the most appropriate next step for the patient.</td>
<td>IT-6.4 ED appropriate utilization</td>
<td>$10,411,457</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>City of Houston Department of Health and Human Services</td>
<td>0937740-08</td>
<td>2.6</td>
<td>2.13.2 - Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner.</td>
<td>The Sobering Center will be a medically supervised facility. It will offer in-patient or outpatient care to intoxicated individuals.</td>
<td>IT-6.4 Other Outcome Improvement Target (Non-emergent ER visits and hospitalizations to Sobering Center Participants)</td>
<td>$7,716,557</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>7</td>
<td>City of Houston Department of Health and Human Services</td>
<td>0937740-08</td>
<td>2.5</td>
<td>2.3.6 - Expand Chronic Care Management Models- “Ohio”: Diabetes Awareness and Wellness Network Center (DAWN)</td>
<td>This project would establish a comprehensive, community based Diabetes Wellness Center in an underserved community with one of the highest incidence rates of diabetes.</td>
<td>IT-5.10 Diabetes care: HbA1c poor control P-1.9.0.0.7- NQF 0059</td>
<td>$9,946,981</td>
<td></td>
</tr>
<tr>
<td>Pass</td>
<td>Category</td>
<td>Performing Provider</td>
<td>TPI</td>
<td>Project Unique ID Number</td>
<td>Project Title (include unique RHP project ID number for each project)</td>
<td>Brief Project Description</td>
<td>Related Category 3 Outcome Measure(s)</td>
<td>Related Category 3 Outcome Measure(s) Title</td>
<td>Estimated Incentive Amount (DSIRF) for DPs 2-5 (Expected Value of $1 &amp; $2 values)</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>---------------------</td>
<td>-----</td>
<td>--------------------------</td>
<td>-------------------------------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>City of Houston Department of Health and Human Services</td>
<td>0937740-08</td>
<td>0937740-08.2.1</td>
<td>2.6 Engage community health workers in an evidence-based program to increase health literacy among a targeted population.</td>
<td>The Healthy Home Fall Prevention project proposes to utilize community health workers to provide essential education related to fall prevention and safety as critical components to the health and well-being of older adults (65+ years) in the community.</td>
<td>0937740-08.5.4</td>
<td>FT-9.4- Other Outcome Improvement Target (ED appropriate utilization)</td>
<td>$7,888,709</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>City of Houston Department of Health and Human Services</td>
<td>0937740-08</td>
<td>0937740-08.2.7</td>
<td>2.8.4- Implement other evidence-based projects to implement health promotion program: Nurse Family Partnership (NFP)</td>
<td>This project would expand the Nurse Family Partnership (NFP) program, which is an evidence-based home visitation program for first-time mothers. NFP utilizes Bachechi-registered Nurses to conduct home visits.</td>
<td>0937740-08.5.1</td>
<td>FT-6.2- Percentage of Low Birth-weight Neonates (CDSRBA.NSF # 1352263)</td>
<td>$10,019,915</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>City of Houston Department of Health and Human Services</td>
<td>0937740-08</td>
<td>0937740-08.2.4</td>
<td>2.7.1- Expand Patient Care Navigation Program: TR Rapid Identification, Treatment and Recovery Project</td>
<td>Project proposes to rapidly identify active tuberculosis (TB) cases, infectious cases and more accurately screen contacts for TB infection, and reduce the length of treatment through the coordination of short course therapy.</td>
<td>0937740-08.5.7</td>
<td>FT-4.10- Other Outcome Improvement Target</td>
<td>$9,945,509</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>City of Houston Department of Health and Human Services</td>
<td>0937740-08</td>
<td>0937740-08.2.2</td>
<td>2.9.1- Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized care: Houston Links</td>
<td>Coordination Links project provides to care coordination that will reduce the frequency of non-urgent ambulance runs and ER visits and link 911 callers to appropriate primary and preventive care in lieu of unnecessary emergency room care.</td>
<td>0937740-08.5.3</td>
<td>FT-9.4- Other Outcome Improvement Target (ED appropriate utilization)</td>
<td>$9,731,918</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>City of Houston Department of Health and Human Services</td>
<td>0937740-08</td>
<td>0937740-08.2.5</td>
<td>2.9.1- Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: HV Service Linkage Project</td>
<td>This service linkage expansion will provide navigation services to targeted patients with EDV who are at high risk of disconnect from institutionalized health care.</td>
<td>0937740-08.5.6</td>
<td>FT-9.6- ED appropriate utilization (Stand-alone metrics)</td>
<td>$9,110,018</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>City of Houston Department of Health and Human Services</td>
<td>0937740-08</td>
<td>0937740-08.1.1</td>
<td>2.3.9- Expansion of school-based mutan and/or fluoride varins</td>
<td>These clinics would create same day clinics that offer same day episodic primary and specialty care during extended hours to meet demand that saturated Harris Health Community Health Centers cannot meet.</td>
<td>0937740-08.5.1</td>
<td>FT-7.1- Dental Students: Percentage of children ages 8-9 with a dental sealant on a permanent first molar tooth</td>
<td>$10,478,250</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>El Camino Memorial Hospital</td>
<td>130102304</td>
<td>030102304.1.1</td>
<td>3.7.3- Implement Telemedicine Program to Provide or Expand Specialist Rerlled Services in an Area Identified as Needed</td>
<td>We will be adding an elective pharmacy capability via telemedicine for the weekends starting with four hours per day and expanding to eight hours per day</td>
<td>030102304.3.1</td>
<td>FT-1.5- All cause 30-day readmission rate - NQF 1782025</td>
<td>$449,950</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Fort Bend County Clinical Health Services</td>
<td>2967606-01</td>
<td>2967606-01.1</td>
<td>1.3.1-1 Develop behavioral health crisis stabilization services as an alternative to hospitalization: Fort Bend County Behavioral Health Crisis Response and Intervention</td>
<td>Fort Bend County (FBC) proposes to develop a crisis system that better identifies people with behavioral health needs, responds to those needs and links patients with their most appropriate level of care.</td>
<td>2967606-01.3.1</td>
<td>FT-9.2- ED Appropriate Utilization</td>
<td>$8,840,021</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Fort Bend County Clinical Health Services</td>
<td>2967606-01</td>
<td>2967606-01.1.2</td>
<td>2.3.2- Expand Existing Primary Care Capacity - Extended Hours of Service</td>
<td>Fort Bend County proposes a project to expand the hours of operation of the local Federally Qualified Health Center (FQHC) to accommodate the increased need in service by Indigent Health Care, Medicaid and uninsured patients who are referred into the clinic from the other projects proposed by Fort Bend County.</td>
<td>2967606-01.5.10</td>
<td>FT-1.3- Third Available Appointment</td>
<td>$1,810,009</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Fort Bend County Clinical Health Services</td>
<td>2967606-01</td>
<td>2967606-01.2.2</td>
<td>2.3.3- Provide an intervention for a targeted behavioral health population to preserve community use of services in a specific setting: Juvenile Justice System</td>
<td>Design, implement and evaluate research supported and evidence based interventions tailored towards individuals in the target population: youth with complex behavioral health needs involved or at risk of involvement in the juvenile justice system.</td>
<td>2967606-01.5.11</td>
<td>FT-9.1- Increase in mental health admissions and readmissions to criminal justice settings (Chronic Detention)</td>
<td>$661,274</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Fort Bend County Clinical Health Services</td>
<td>2967606-01</td>
<td>2967606-01.2.3</td>
<td>2.5.2- Other project option - Implement other evidence-based projects to redesign primary- Community Paramedic Program</td>
<td>Fort Bend County proposes a project which would identify Indigent Health Care, Medicaid and uninsured patients who are frequent or inappropriate users of County Emergency Medical Service (EMS) and hospital Emergency Departments (EDs) to provide appropriate care in their home setting.</td>
<td>2967606-01.5.5</td>
<td>FT-5.5- Reduce number of inappropriate EMS transports</td>
<td>$661,274</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Fort Bend County Clinical Health Services</td>
<td>2967606-01</td>
<td>2967606-01.2.4</td>
<td>2.7.1- Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations: Colonoscopy Screening</td>
<td>Fort Bend County proposes a project where Indigent Health Care, Medicaid and uninsured patients who must guidelines for screening or diagnostic colonoscopies are referred to a local medical provider for this procedure. Under contract with Fort Bend County Clinical Health Services, the local medical provider (negotiations underway) would provide the following:</td>
<td>2967606-01.5.3</td>
<td>FT-5.1- Patient experience with access to specialists, Shared decision making</td>
<td>$473,278</td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan
Region 3
16
<table>
<thead>
<tr>
<th>Pass</th>
<th>Category</th>
<th>Performing Provider</th>
<th>TPI</th>
<th>Project Unique ID Number</th>
<th>Project Title (include unique RHP project ID number for each project)</th>
<th>Brief Project Description</th>
<th>Related Category 3 Outcome Measure(s) Unique Identifier</th>
<th>Related Category 3 Outcome Measure(s) Title</th>
<th>Estimated Incentive Amount (DSRIP) for FYs 2-5 (Category 1 &amp; 2 values)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>Fort Bend County Clinical Health Services</td>
<td>2967606.01</td>
<td>2967606.2.5</td>
<td>2.9.1 - Establish/expand a Patient Navigation Program</td>
<td>A project where Indigent Health Care, Medicaid and uninsured patients who are frequent or inappropriate users of the County Emergency Medical Service (EMS) and hospital Emergency Departments (EDs) who have repeat admissions to the hospital would be referred into a case management system based in the local Federally Qualified Health Center.</td>
<td>2967606.3.2</td>
<td>IT-5.10 Diabetes Care: HbA1c Poor Control (&gt;9.1%)</td>
<td>$2,993,949</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>Gulf Coast Medical Center</td>
<td>17815001.1</td>
<td>17815001.3.1</td>
<td>1.9.2 - Expand/improve specialty care capacity in most impacted medical specialties: Establish Adult Inpatient Psychiatric Unit</td>
<td>1.14 Other: Implement other specialty services</td>
<td>17815001.3.2</td>
<td>IT-9.5 Eliminate inappropriate Utilization</td>
<td>$3,823,217</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Gulf Coast Medical Center</td>
<td>13355104.1.1</td>
<td>13355104.3.1</td>
<td>1.1-1 Establish new primary care clinics: Gulfgate Area Same Day Access Clinic</td>
<td>These clinics would offer same day episodic primary and specialty care for extended hours to meet demand that saturated Harris Health System Community Health Centers cannot meet.</td>
<td>13355104.3.1</td>
<td>IT-6.2 Percent improvement over baseline of patient satisfaction scores</td>
<td>$29,164,032</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>Harris Health System</td>
<td>13355104.1.10</td>
<td>13355104.1.10</td>
<td>1.12-4 Enhance service availability of appropriate levels of behavioral health care: Expansion of Ambulatory Mental Health Services</td>
<td>Harris Health System proposes to enhance service availability of appropriate levels of behavioral health care by expanding mental health services in the ambulatory care setting.</td>
<td>13355104.3.12</td>
<td>IT-1.19 Antidepressant management</td>
<td>$21,644,687</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>Harris Health System</td>
<td>13355104.1.11</td>
<td>13355104.1.11</td>
<td>3.3.1- Implement Enhance and Use Chronic Disease Management Registry Functionalities: Implement Chronic Disease Management Registry</td>
<td>This would utilize electronic software to identify populations at risk, and improve provider and patient management of chronic disease.</td>
<td>13355104.3.13</td>
<td>IT-5.2 Congruent Heart Failure: 30-day readmission rate</td>
<td>$19,716,687</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>Harris Health System</td>
<td>13355104.1.12</td>
<td>13355104.1.12</td>
<td>1.10-4 Innovation Center for Quality</td>
<td>Harris Health System proposes to establish a Center of Innovation to expand quality improvement capacity through people, processes and technology so that the resources are in place to conduct, report, drive and measure quality improvement.</td>
<td>13355104.3.14</td>
<td>IT-6.6 Hospital-Acquired Venous Thromboembolism rates</td>
<td>$36,566,250</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>Harris Health System</td>
<td>13355104.1.13</td>
<td>13355104.1.13</td>
<td>1.9-2 Improve access to specialty care: Increase access to outpatient Physical and Occupational Therapy services</td>
<td>This project will increase the number of outpatient physical and occupational therapy providers in order to improve access and meet unmet demand for patients who are being referred for services from NCHA medical homes and specialty clinics.</td>
<td>13355104.3.18</td>
<td>IT-10.1 Quality of Life</td>
<td>$14,644,436</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>Harris Health System</td>
<td>13355104.1.14</td>
<td>13355104.1.14</td>
<td>1.1-1 Establish new primary care clinic: Casa de Amigos Same Day Access Clinic</td>
<td>This project will expand the capacity of primary care by establishing an adult-focused primary care clinic near the current Casa de Amigos Health Center that offers same day visits during extended hours to meet demand that saturated existing Harris Health System health centers cannot meet.</td>
<td>13355104.3.19</td>
<td>IT-6.2 Percent improvement over baseline of patient satisfaction</td>
<td>$28,922,270</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
<td>Harris Health System</td>
<td>13355104.1.15</td>
<td>13355104.1.15</td>
<td>3.9.6 - The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours: Increase, Expand, and Enhance Oral Health Services: Expansion of Adult Dental Services</td>
<td>This project will expand adult dental services by establishing additional sites and expanding services at current sites. Services will be added or expanded at 7 health centers.</td>
<td>13355104.3.20</td>
<td>IT-7.8 Chronic Disease Patients Accessing Dental Services</td>
<td>$26,342,678</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>Harris Health System</td>
<td>13355104.1.16</td>
<td>13355104.1.16</td>
<td>1.14 Other: Implement other violence-based project to expand primary care capacity: House Calls Program</td>
<td>This project will expand the House Calls Program in order to improve access, minimize independence, and reduce cost savings by providing comprehensive, coordinated multidisciplinary primary care at home to a population of patients that are homebound or have difficulty getting to clinic visits.</td>
<td>13355104.3.21</td>
<td>IT-9.2 ED appropriate utilization</td>
<td>$11,217,312</td>
</tr>
<tr>
<td>Pass</td>
<td>Category</td>
<td>Performing Provider</td>
<td>TPI</td>
<td>Project Unique ID Number</td>
<td>Project Title (include unique HIP project ID number for each project)</td>
<td>Brief Project Description</td>
<td>Related Category 3 Outcome Measure(s)</td>
<td>Related Category 3 Outcome Measure(s)</td>
<td>Estimated Incentive Amount (DSRIP) for DVs 2.5 (Category 1 &amp; 2 values)</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>--------------------------</td>
<td>-----</td>
<td>--------------------------</td>
<td>---------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------</td>
<td>-------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Harris Health System</td>
<td>133355104</td>
<td>133355104.1.7</td>
<td>1.1.2-Expand Existing Primary Care Capacity: Expansion of Pediatric Dental Services</td>
<td>This project will address the growing need for pediatric oral health services by implementing these services across three facilities within our system.</td>
<td>IT-1.10 Diabetes Care: HbA1c poor control (&gt;9.0%)</td>
<td>IT-6.2 Percent improvement over baseline of patient satisfaction scores</td>
<td>$20,004,476</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Harris Health System</td>
<td>133355104</td>
<td>133355104.1.2</td>
<td>1.1.1-Establish more primary care clinics: People’s Area Same Day Access Clinic</td>
<td>These clinics would create same day clinics that offer same day episodic primary and specialty care during extended hours to meet demand that saturated Harris Health Community Health Centers cannot meet.</td>
<td>IT-7.2 Dental Sealant: percentage of children with dental sealants</td>
<td>IT-6.2 Percent improvement over baseline of patient satisfaction scores</td>
<td>$29,164,032</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Harris Health System</td>
<td>133355104</td>
<td>133355104.1.3</td>
<td>1.1.2-Expand Existing Primary Care Capacity: Expansion of Eastern Health Centers</td>
<td>This clinic would create same day clinics that offer same day episodic primary and specialty care during extended hours to meet demand that saturated Harris Health Community Health Centers cannot meet.</td>
<td>IT-1.3 Third Next Available Appointment: Efficiency in an innovative manner not described in the unique RHP based project to expand specialty care capacity</td>
<td>IT-6.2 Percent improvement over baseline of patient satisfaction scores</td>
<td>$57,954,751</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Harris Health System</td>
<td>133355104</td>
<td>133355104.1.4</td>
<td>1.1.1-Establish a primary care clinic: West and Northeast 1 Area Health Centers</td>
<td>Harris Health System proposes a project to improve the capacity of primary care by adding the Northwest 2 and Northeast 3 Area Health Centers to the compliment of existing health centers to establish Medical Homes primarily for the adult population.</td>
<td>IT-1.3 Third Next Available Appointment: Efficiency in an innovative manner</td>
<td>IT-6.2 Percent improvement over baseline of patient satisfaction scores</td>
<td>$28,754,914</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Harris Health System</td>
<td>133355104</td>
<td>133355104.1.5</td>
<td>1.1.1-Establish more primary care clinics: Northwest 2 and Northwest 3 Area Health Centers</td>
<td>These centers would provide on-demand same day care with a focus on high-risk mothers. This project will focus on developing a randomized controlled trial to address diabetes mellitus and hypertension.</td>
<td>IT-7.2 Dental Sealant: percentage of children with dental sealants</td>
<td>IT-6.2 Percent improvement over baseline of patient satisfaction scores</td>
<td>$34,226,582</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Harris Health System</td>
<td>133355104</td>
<td>133355104.1.6</td>
<td>1.1.1-Establish more primary care clinics: SouthEast, Medical Center, and Northwest Same Day Access Clinics</td>
<td>This clinic would create same day clinics that offer same day episodic primary and specialty care during extended hours to meet demand that saturated Harris Health Community Health Centers cannot meet.</td>
<td>IT-6.2 Percent improvement over baseline of patient satisfaction scores</td>
<td>IT-6.2 Percent improvement over baseline of patient satisfaction scores</td>
<td>$87,915,332</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Harris Health System</td>
<td>133355104</td>
<td>133355104.1.7</td>
<td>1.1.2-Expand Existing Primary Care Capacity: Expansion of Pediatric Health Services</td>
<td>This project will address the shortage of pediatric and adolescent behavioral health services by implementing and expanding these services across eight facilities within the system.</td>
<td>IT-1.3 Third Next Available Appointment: Efficiency in an innovative manner</td>
<td>IT-6.2 Percent improvement over baseline of patient satisfaction scores</td>
<td>$20,004,476</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Harris Health System</td>
<td>133355104</td>
<td>133355104.1.8</td>
<td>1.2.1-Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Expansion of Pediatric Behavioral Health Services</td>
<td>Harris Health System will address Project Option 1.12.2 related to the shortage of pediatric and adolescent behavioral health services by implementing and expanding these services across eight facilities within the system.</td>
<td>IT-6.2 Percent improvement over baseline of patient satisfaction scores</td>
<td>IT-6.2 Percent improvement over baseline of patient satisfaction scores</td>
<td>$20,004,476</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Harris Health System</td>
<td>133355104</td>
<td>133355104.1.9</td>
<td>1.2.1-Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Expansion of Pediatric Behavioral Health Services</td>
<td>Harris Health System proposes to expand the capacity of primary care by adding additional primary care providers and staff to locally Federally Qualified Health Centers in order to meet the demand that saturated existing Harris Health System health centers cannot meet.</td>
<td>IT-5.1 Third Next Available Appointment: Efficiency in an innovative manner</td>
<td>IT-6.2 Percent improvement over baseline of patient satisfaction scores</td>
<td>$33,226,582</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Harris Health System</td>
<td>133355104</td>
<td>133355104.2.1</td>
<td>Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: Reduce ER Utilization for Top Frequents</td>
<td>Harris Health System proposes a project that will target top ER frequent and ensure they are managed appropriately to receive the right care in the right setting.</td>
<td>IT-4.4 Reduce ED Visits for Frequent User Cohort</td>
<td>IT-6.2 Percent improvement over baseline of patient satisfaction scores</td>
<td>$12,801,250</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Harris Health System</td>
<td>133355104</td>
<td>133355104.2.2</td>
<td>Reduce Inappropriate ED Use: Emergency Center Advanced Triage Care</td>
<td>This project will improve access to pre- and postnatal care through comprehensive, effective patient navigation through the Harris Health System and throughout a woman’s pregnancy, with a focus on high-risk mothers.</td>
<td>IT-4.4 Reduce LWBS for ESI Levels 4 and 5</td>
<td>IT-6.2 Percent improvement over baseline of patient satisfaction scores</td>
<td>$10,042,122</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Harris Health System</td>
<td>133355104</td>
<td>133355104.2.3</td>
<td>1.1.1-Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: OB Navigation Program</td>
<td>This project will improve access to pre- and postnatal care through comprehensive, effective patient navigation through the Harris Health System and throughout a woman’s pregnancy, with a focus on high-risk mothers.</td>
<td>IT-4.4 Reduce LWBS for ESI Levels 4 and 5</td>
<td>IT-6.2 Percent improvement over baseline of patient satisfaction scores</td>
<td>$21,023,764</td>
</tr>
<tr>
<td>Pass</td>
<td>Category</td>
<td>Performing Provider</td>
<td>TPI</td>
<td>Project Unique ID Number</td>
<td>Project Title (include unique RHP project ID number for each project)</td>
<td>Brief Project Description</td>
<td>Related Category 3 Outcome Measure(s) Unique Identifier</td>
<td>Related Category 3 Outcome Measure(s) Title</td>
<td>Estimated Incentive Amount (DSRIP) for FYs 2-5 (Category 1 &amp; 2 values)</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>---------------------</td>
<td>-----</td>
<td>--------------------------</td>
<td>--------------------------------------------------------</td>
<td>--------------------------</td>
<td>------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Harris Health System</td>
<td>133355104</td>
<td>133355104.2.5</td>
<td>2.1.1 - Redesign the outpatient delivery system to coordinate care for patients with chronic diseases: Expansion of Point-of-Care Services Provided by Clinical Pharmacists</td>
<td>This project will expand point-of-care services provided by clinical pharmacists for the chronic management of patients receiving anticoagulation therapy and create an educational website.</td>
<td>133355104.3.25</td>
<td>IT-2.20 Other: Management of DSR</td>
<td>$10,048,795</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>133355104.3.26</td>
<td>IT-2.13 Other Outcome Measure</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Harris Health System</td>
<td>133355104</td>
<td>133355104.2.6</td>
<td>2.4.4 - Implement Evidence-based Practice in a Collaborative Manner: Integrated Promotions-of-Fruit and Vegetable Consumption in Primary Care Through a Prescription for Healthy Eating Program</td>
<td>This project will develop a program for promoting increased consumption of fruits and vegetables among primary care patients through an integrated approach that includes multi-provider and multi-modal patient education and access to a clinic-based farmer’s market.</td>
<td>133355104.3.27</td>
<td>IT-6.3 Percent increase over baseline of patient satisfaction scores</td>
<td>$4,311,404</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Harris Health System</td>
<td>133355104</td>
<td>133355104.2.7</td>
<td>2.10.2 - “Other”: Implement other evidence-based project to implement use of palliative care programs: Use of Palliative Care Programs</td>
<td>This project will expand our comprehensive palliative care program through the creation of an integrated, interprofessional team of specially trained providers.</td>
<td>133355104.3.28</td>
<td>IT-15.1 Plan Assessment</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>133355104.3.29</td>
<td>IT-15.4 Proportion admitted to ICU in last 30 days of life</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Matagorda Regional Medical Center</td>
<td>130699304</td>
<td>130699304.1.3</td>
<td>1.6.1 - Expand Urgent Care Services: Increase Access to Urgent Care Services and Urgent Medical Advice</td>
<td>A joint planning team with representatives of Matagorda County Hospital District/Matagorda Regional Medical Center, Matagorda Episcopal Health Outreach Program (MEHOP – FPWC), and Palacios Community Medical Center has explored potential models to transform access, cost and delivery of health care. The transformation goals described in the Waiver helped the group crystallize their plans and a new partnership was formed to move the joint planning effort forward. This new organization, Coastal Health Connection, is currently being incorporated with these three organizations as the founders to further the concept of shared infrastructure and shared planning to improve the health of the community.</td>
<td>130699304.3.3</td>
<td>IT-9.2 ED Appropriate Utilization</td>
<td>$2,192,047</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Matagorda Regional Medical Center</td>
<td>130699304</td>
<td>130699304.1.1</td>
<td>1.9.2 - Improve access to specialty care: Establish a Chronic Disease Clinic to Expand Access to Specialty Care</td>
<td>Matagorda Regional Medical Center proposes to expand specialty care for targeted populations with chronic disease.</td>
<td>130699304.3.1</td>
<td>IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Matagorda Regional Medical Center</td>
<td>130699304</td>
<td>130699304.2.1</td>
<td>2.9.1 - Provide navigation services to eligible patients who are at risk of disenrollment from institutionalized health care: Establish a Patient Care Navigation Program</td>
<td>Develop a regional approach to health care delivery that leverages and improves existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.</td>
<td>130699304.3.2</td>
<td>IT-9.2 ED Appropriate Utilization</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>The University of Texas MD Anderson Cancer Center</td>
<td>12672402</td>
<td>12672402.2.4</td>
<td>2.7.1 - Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g. mammography screening, colorectal cancer, prenatal alcohol use, etc.): Expand Project VALET</td>
<td>The overarching goal of the proposed project, Replicating Ask Advise Connect (AAC), is to deliver evidence-based smoking cessation treatment to smokers seeking care in Federally Qualified Health Centers (FQHC) in Harris County, Texas, and to ultimately reduce tobacco-related morbidity and mortality, particularly among individuals who are disproportionately burdened with the disease.</td>
<td>12672402.3.10</td>
<td>IT-12.6 Other Outcome Improvement Target: Women in need of diagnostic tests</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12672402.3.11</td>
<td>IT-12.6 Other Outcome Improvement Target: Women returning for an annual mammogram per recommended screening guidelines.</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Memorial Medical Center</td>
<td>137909111</td>
<td>137909111.2.2</td>
<td>2.4.1 - Develop and implement a structural patient experience training program: Improving the Patient Experience – The AIDET or similar Project</td>
<td>Memorial Medical Center will develop and implement a structural patient experience training program: Improving the Patient Experience – The AIDET Project.</td>
<td>137909111.3.3</td>
<td>IT-6.1 (1) Improve Patient Satisfaction</td>
<td>$634,817</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Memorial Medical Center</td>
<td>137909111</td>
<td>137909111.2.3</td>
<td>2.4.3 - Improving the Patient Experience – Hospitalist Model</td>
<td>Under this project, Memorial Medical Center will research, design, and implement (if found to be effective) a hospitalist model to increase productivity and access to care for patients, involving both physicians and hospital providers.</td>
<td>137909111.3.4</td>
<td>IT-6.1 (1) Improve Patient Satisfaction</td>
<td>$1,314,452</td>
</tr>
<tr>
<td>Pass</td>
<td>Category</td>
<td>Performing Provider</td>
<td>TPF</td>
<td>Project Unique ID Number</td>
<td>Project Title (include unique HIP project ID number for each project)</td>
<td>Brief Project Description</td>
<td>Related Category 3 Outcome Measure(s) Unique Identifier</td>
<td>Related Category 3 Outcome Measure(s) Title</td>
<td>Estimated Incentive Amount (DSHRP) for FYs 2-5 (Category 1 &amp; 2 values)</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>---------------------</td>
<td>-----</td>
<td>--------------------------</td>
<td>-------------------------------------------------</td>
<td>--------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Memorial Medical Center</td>
<td>137909111</td>
<td>137909111.2.1</td>
<td>2.5.4 – “Other” project option: Implement other evidence-based project that will impact cost efficiency in an innovative manner: Medication Dispensing Safety and Efficiency</td>
<td>To avoid errors during the administration of medications, we would implement bedside bar-code scanning utilizing Compass on Wheels (COWs). Further, by using a dispensing system with COWs, nursing staff will have more time to spend with the patients assisting with their recovery process resulting in decreased length of stay and cost savings.</td>
<td>137909111.3.2</td>
<td>IT-5.1 Improved Cost Savings; demonstrate cost savings in care delivery</td>
<td>$387,300</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Memorial Medical Center</td>
<td>137909111</td>
<td>137909111.3.1</td>
<td>3.1.4 – Other project option: Hospital-based clinic improving access to primary and specialty care</td>
<td>Expand access to primary and specialty care services through the establishment of a hospital-based clinic. The clinic will offer expanded and non-traditional hours of care.</td>
<td>137909111.3.5</td>
<td>IT-6.1.1 Patient Satisfaction</td>
<td>$2,446,150</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td>113180703.3.1</td>
<td>3.12 Enhance service availability of appropriate levels of behavioral health care: expansion of outpatient behavioral health services for adults with severe psychiatric conditions</td>
<td>The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to enhance service availability of appropriate levels of behavioral health care and expand outpatient behavioral health services for adults with severe psychiatric conditions.</td>
<td>113180703.5.1</td>
<td>IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
<td>$13,188,403</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td>113180703.3.10</td>
<td>3.9.2 – Expand Specialty Care Capacity: Lighthouse</td>
<td>Along with the Lighthouse, MHMRA proposes to expand behavioral healthcare capacity for persons with visual impairment to include identification of behavioral health needs, interventions, case management, patient and family education and coordination with primary care.</td>
<td>113180703.5.19</td>
<td>IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
<td>$2,816,614</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td>113180703.3.13</td>
<td>3.9 Expand specialty care capacity: IDD specialized treatment and rehabilitative services (STARS)</td>
<td>The Mental Health and Mental Retardation Authority (MHMRA) proposes to expand specialty care capacity by expanding IDD specialized treatment and rehabilitative services (STARS).</td>
<td>113180703.5.29</td>
<td>IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
<td>$6,890,613</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td>113180703.3.14</td>
<td>3.12 Enhance service availability of appropriate levels of behavioral health care: expansion of outpatient behavioral health services for adults with severe psychiatric conditions (Northeast)</td>
<td>MHMRA of Harris County proposes to enhance service availability of behavioral health care by expanding outpatient services for adults with severe psychiatric conditions (Northeast).</td>
<td>113180703.5.24</td>
<td>IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
<td>$13,188,403</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td>113180703.3.15</td>
<td>3.12 Enhance service availability of appropriate levels of behavioral health care: expansion of outpatient behavioral health services for adults with severe psychiatric (Southwest)</td>
<td>The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to enhance service availability of appropriate levels of behavioral health care and expand outpatient behavioral health services for adults with severe psychiatric.</td>
<td>113180703.5.25</td>
<td>IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
<td>$13,188,403</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td>113180703.3.16</td>
<td>3.12 Enhance service availability of appropriate levels of behavioral health care: expansion of outpatient behavioral health services for adults with severe psychiatric (Southeast)</td>
<td>The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to enhance service availability of appropriate levels of behavioral health care and expand outpatient behavioral health services for adults with severe psychiatric.</td>
<td>113180703.5.26</td>
<td>IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
<td>$13,188,403</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td>113180703.3.17</td>
<td>3.12 Enhance service availability of appropriate levels of behavioral health care: expansion of outpatient behavioral health services for adults with severe psychiatric (Region determined according to need)</td>
<td>The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to enhance service availability of appropriate levels of behavioral health care and expand outpatient behavioral health services for adults with severe psychiatric.</td>
<td>113180703.5.27</td>
<td>IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
<td>$13,188,403</td>
</tr>
<tr>
<td>Pass</td>
<td>Category</td>
<td>Performing Provider</td>
<td>TPI</td>
<td>Project Unique ID Number</td>
<td>Project Title (include unique RHP project ID number for each project.)</td>
<td>Brief Project Description</td>
<td>Related Category 3 Outcome Measure(s) Unique Identifier</td>
<td>Related Category 3 Outcome Measure(s) Title</td>
<td>Estimated Incentive Amount (DSRIP) for FYs 2-5 (Category 1 &amp; 2 values)</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>---------------------</td>
<td>-----</td>
<td>--------------------------</td>
<td>-------------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td>213180703.1.8</td>
<td>3.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Interim Care Clinic. The Interim Care Clinic (ICC) is designed to provide initial evaluation and treatment to individuals presenting at the MHMRA Psychiatric Emergency Service (PES) voluntarily, who are not in acute crisis, but who are in urgent need of assessment and treatment to avoid further deterioration of their psychiatric condition. These individuals are diverted from submission to the PES and offered a same day evaluation with an intercare clinic psychiatrist. The clinic is designed to be a single visit clinic and no return or follow-up appointments are given, although patients may return if needed. The project proposes to have the clinic available seven days a week, excluding extended evening hours.</td>
<td>IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
<td>$12,561,090</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td>213180703.1.9</td>
<td>3.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved zones: Clubhouse Expansion. MHMRA will be contracting with St. Joseph House to provide psychosocial rehabilitation services. St. Joseph House is an accredited Clubhouse and adheres to the standards of the International Center for Clubhouse Development (ICCD). The ICCD Clubhouse Model is a day treatment program for rehabilitating individuals with a serious and persistent mental health problem.</td>
<td>IT-9.1 Increase in mental health admissions and readmissions to criminal justice settings</td>
<td>$6,584,745</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td>213180703.1.11</td>
<td>3.13.1 Development of Behavioral Health Crisis Stabilization Services as Alternatives to Hospitalization: Crisis Residential Unit. For this project, MHMRA seeks to expand the Crisis Residential Unit (CRIU). This 24-bed unit is specifically designed as a step-down from hospitalization with the goal of reducing the number of bed-days required for acute psychiatric hospitalization, reducing hospitalization re-admission rates, and increasing tenure in the community and utilization of outpatient treatment alternatives.</td>
<td>IT-10.1. Improvement in functional status</td>
<td>$19,441,205</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td>213180703.2.1</td>
<td>2.15.1 Integrate primary and behavioral health care services: collaborative primary medical and behavioral health care Mental Health and Mental Retardation Authority of Harris County. The Mental Health and Mental Retardation Authority of Harris County proposes to integrate primary and behavioral health care services.</td>
<td>IT-9.1 Functional Assessment</td>
<td>$19,142,531</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td>213180703.2.2</td>
<td>2.13.1 Provide an intervention for targeted behavioral health populations to prevent unnecessary use of services in a specified setting: Integrating substance abuse treatment services into mental health services.</td>
<td>IT-6.6 Percent improvement over baseline of patient satisfaction scores</td>
<td>$18,419,173</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td>213180703.2.3</td>
<td>2.17.1 Establish improvements in care transition from the inpatient setting for individuals with mental health disorders: redesign of the transition from HCPC to MHMRA outpatient clinic. The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to establish improvements in care transition from the inpatient setting for individuals with mental health disorders by redesigning the transition from HCPC to MHMRA outpatient clinic.</td>
<td>IT-6.1 Functional Assessment</td>
<td>$2,212,418</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td>213180703.2.4</td>
<td>2.13.1 Provide an intervention for targeted behavioral health populations to prevent unnecessary use of services in a specified setting: Expanding consumer stabilization initiative.</td>
<td>IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
<td>$1,370,948</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td>213180703.2.5</td>
<td>2.13.1 Provide an intervention for targeted behavioral health populations to prevent unnecessary use of services in a specified setting: Expansion of mobile crisis unit. The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to provide an intervention for targeted behavioral health populations to prevent unnecessary use of services in a specified setting by expansion of a mobile crisis unit.</td>
<td>IT-6.1 Percent improvement over baseline of patient satisfaction scores</td>
<td>$11,919,410</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan
Region 3

21
<table>
<thead>
<tr>
<th>#</th>
<th>Category</th>
<th>Performing Provider</th>
<th>TPI</th>
<th>Project Unique ID Number</th>
<th>Project Title (include unique RHP project ID number for each project.)</th>
<th>Brief Project Description</th>
<th>Related Category 3 Outcome Measure(s)</th>
<th>Related Category 3 Outcome Measure(s) Title</th>
<th>Estimated Incentive Amount (DSRIP) for FYs 2-5 (Category 1 &amp; 2 values)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113107003</td>
<td>113107003.2.6</td>
<td>2.1.5.1: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: transitional residential treatment/peer incarceration</td>
<td>The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: transitional residential treatment/peer incarceration.</td>
<td>IT-6.1.1. Percent improvement over baseline of patient satisfaction scores</td>
<td>IT-10.1. Improvement in functional status</td>
<td>$14,222,989</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113107003</td>
<td>113107003.2.7</td>
<td>2.1.5.1: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: crisis intervention response team (CIRT)</td>
<td>The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting by expansion of a crisis intervention response team.</td>
<td>IT-9.1. Decrease in mental health admissions and readmissions to criminal justice settings</td>
<td>IT-6.1. Patient Satisfaction</td>
<td>$7,215,482</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113107003</td>
<td>113107003.2.8</td>
<td>2.1.5.1: Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: I/DD/ASD Wrap-Around and In-Home Services</td>
<td>The proposal program seeks to develop wrap-around and in-home services for high risk consumers with Intellectual and Developmental Disabilities and Autism Spectrum Disorders (I/DD and ASD) and their families to avoid utilization of intensive, costly services. More specifically, program staff will provide community-based interventions for individuals to prevent them from cycling through multiple systems, by providing community-based, wrap-around services that help address behavioral problems in the natural home, while linking the patient and family to other supports, such as a medical home, transition services to help individuals establish a stable living environment, peer support, employment, specialized therapies, respite, personal assistance, and linkage to short or long term residential options.</td>
<td>IT-6.1.1. Percent improvement over baseline of patient satisfaction scores</td>
<td>IT-10.2. Activities of Daily Living</td>
<td>$6,676,987</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113107003</td>
<td>113107003.2.9</td>
<td>2.1.7.2 Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders – I/DD/ASD Inpatient Consultation and Liaison Service</td>
<td>MHMRA proposes to expand and further develop the Inpatient Consultation and Liaison (C&amp;L) team that provides consultation and services to patients suspected of Intellectual and Developmental Disabilities and Autism Spectrum Disorders (I/DD and ASD) referred by attending physicians at the Harris County Psychiatric Center (HCPC), with subsequent expansions to provide similar services to other inpatient settings in Harris County. This model is intended to divert people with I/DD/ASD from higher cost, inpatient placement and into local resources. Accordingly, this project aims to improve and expand care transitions programs.</td>
<td>IT-2.13 Other Admissions Rate: Rate of Admission: into State Supported Institutional Care</td>
<td>IT-3.46 Behavioral Health Substance Abuse 30-Day readmission rate</td>
<td>$6,676,987</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>OakLea Medical Center</td>
<td>127303903</td>
<td>127303903.1.1</td>
<td>1.3.1 Implement and Utilize Disease Management Registry Functionality</td>
<td>Receive monthly registry reports on their patients with CHF, COPD, Diabetes and ESRD, OBMC will develop and implement a registry in conjunction with FBFHC and specific home health providers.</td>
<td>IT-3.2 Congestive Heart Failure 30-Day Readmission Rate</td>
<td></td>
<td>$3,602,979</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>OakLea Medical Center</td>
<td>127303903</td>
<td>127303903.2.4</td>
<td>2.1.4.5 “Other” project option: Implement evidence-based project to implement person-centered wellness self-management strategies and self-directed financing models that empower consumers to take charge of their own health care: Person-Centered Wellness Management Program</td>
<td>OBMC will formalize partnerships with local community agencies to work on projects specifically dedicated to health and wellness promotion such as Fort Bend Family Health Center (FBFHC), United Way, OakLea Medical Group (OBMG), Weight Watchers and other agencies. We will form a task force of community members from each of the different agencies to do a needs assessment to determine targeted areas where a wellness management program would be beneficial.</td>
<td>IT-4.1 Chronic Disease 30-Day Readmission Rate</td>
<td></td>
<td>$6,495,976</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>OakLea Medical Center</td>
<td>127303903</td>
<td>127303903.2.1</td>
<td>2.4.1 Implement Consumer Assessment System</td>
<td>OBMC plans to establish a patient experience program where patients feel safe, hear their voices heard and an empowered. This concept would involve staff education on communication skills and will be in line with the other initiatives that are designed to create an environment that promotes excellence, operational efficiency and quality patient-centered care.</td>
<td>IT-2.9 ED appropriate Utilization</td>
<td></td>
<td>$2,785,219</td>
</tr>
<tr>
<td>Pass</td>
<td>Category</td>
<td>Performing Provider</td>
<td>TPI</td>
<td>Project Unique ID Number</td>
<td>Project Title (include unique RHP project ID number for each project)</td>
<td>Brief Project Description</td>
<td>Related Category 3 Outcome Measure(s) Unique Identifier</td>
<td>Related Category 3 Outcome Measure(s) Title</td>
<td>Estimated Incentive Amount (DSRIP) for DPs 2-5 (Category 1 &amp; 2 values)</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>---------------------</td>
<td>-----</td>
<td>--------------------------</td>
<td>---------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>OldHead Medical Center</td>
<td>212060201</td>
<td>212060201.1.1</td>
<td>Rice Medical Center proposes to expand the availability of timely primary care services.</td>
<td>Rice Medical Center proposes to expand primary care access in the greater Colorado County area by establishing an outpatient urgent care clinic in this community and a surrounding radius of at least 10 miles outside the city limits.</td>
<td>212060201.1.1</td>
<td>Rice Medical Center proposes to expand primary care access in the greater Colorado County area by establishing an outpatient urgent care clinic in this community and a surrounding radius of at least 10 miles outside the city limits.</td>
<td>$275,944</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Rice Medical Center</td>
<td>212060201</td>
<td>212060201.1.2</td>
<td>Rice Medical Center proposes to enhance urgent medical advice.</td>
<td>Rice Medical Center proposes to enhance urgent medical advice in Colorado-County by establishing an outpatient urgent care clinic in this hospital facility.</td>
<td>212060201.1.2</td>
<td>Rice Medical Center proposes to enhance urgent medical advice in Colorado-County by establishing an outpatient urgent care clinic in this hospital facility.</td>
<td>$1,357,113</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>OldHead Medical Center</td>
<td>212060201</td>
<td>212060201.1.3</td>
<td>Rice Medical Center proposes to expand primary care access in the greater Colorado County area by establishing a clinic in East Bernard.</td>
<td>Rice Medical Center proposes to expand primary care access in the greater Colorado County area by establishing a clinic in East Bernard.</td>
<td>212060201.1.3</td>
<td>Rice Medical Center proposes to expand primary care access in the greater Colorado County area by establishing a clinic in East Bernard.</td>
<td>$2,491,701</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>Rice Medical Center</td>
<td>212060201</td>
<td>212060201.1.4</td>
<td>Expand current primary care services at Rice Medical Center to include additional services and programs.</td>
<td>Rice Medical Center proposes to enhance urgent medical advice in Colorado-County by establishing an outpatient urgent care clinic in this hospital facility.</td>
<td>212060201.1.4</td>
<td>Rice Medical Center proposes to enhance urgent medical advice in Colorado-County by establishing an outpatient urgent care clinic in this hospital facility.</td>
<td>$3,132,194</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>Rice Medical Center</td>
<td>212060201</td>
<td>212060201.1.5</td>
<td>Rice Medical Center proposes to enhance urgent medical advice in Colorado-County by establishing an outpatient urgent care clinic in this hospital facility.</td>
<td>Rice Medical Center proposes to enhance urgent medical advice in Colorado-County by establishing an outpatient urgent care clinic in this hospital facility.</td>
<td>212060201.1.5</td>
<td>Rice Medical Center proposes to enhance urgent medical advice in Colorado-County by establishing an outpatient urgent care clinic in this hospital facility.</td>
<td>$2,491,701</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>Rice Medical Center</td>
<td>212060201</td>
<td>212060201.1.6</td>
<td>Rice Medical Center proposes to expand primary care access in the greater Colorado County area by establishing a clinic in East Bernard.</td>
<td>Rice Medical Center proposes to expand primary care access in the greater Colorado County area by establishing a clinic in East Bernard.</td>
<td>212060201.1.6</td>
<td>Rice Medical Center proposes to expand primary care access in the greater Colorado County area by establishing a clinic in East Bernard.</td>
<td>$2,491,701</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>Rice Medical Center</td>
<td>212060201</td>
<td>212060201.2.1</td>
<td>Rice Medical Center proposes to enhance urgent medical advice in Colorado-County by establishing an outpatient urgent care clinic in this hospital facility.</td>
<td>Rice Medical Center proposes to enhance urgent medical advice in Colorado-County by establishing an outpatient urgent care clinic in this hospital facility.</td>
<td>212060201.2.1</td>
<td>Rice Medical Center proposes to enhance urgent medical advice in Colorado-County by establishing an outpatient urgent care clinic in this hospital facility.</td>
<td>$1,357,113</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>Rice Medical Center</td>
<td>212060201</td>
<td>212060201.2.2</td>
<td>Rice Medical Center proposes to enhance urgent medical advice in Colorado-County by establishing an outpatient urgent care clinic in this hospital facility.</td>
<td>Rice Medical Center proposes to enhance urgent medical advice in Colorado-County by establishing an outpatient urgent care clinic in this hospital facility.</td>
<td>212060201.2.2</td>
<td>Rice Medical Center proposes to enhance urgent medical advice in Colorado-County by establishing an outpatient urgent care clinic in this hospital facility.</td>
<td>$2,491,701</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>Rice Medical Center</td>
<td>212060201</td>
<td>212060201.2.3</td>
<td>Rice Medical Center proposes to enhance urgent medical advice in Colorado-County by establishing an outpatient urgent care clinic in this hospital facility.</td>
<td>Rice Medical Center proposes to enhance urgent medical advice in Colorado-County by establishing an outpatient urgent care clinic in this hospital facility.</td>
<td>212060201.2.3</td>
<td>Rice Medical Center proposes to enhance urgent medical advice in Colorado-County by establishing an outpatient urgent care clinic in this hospital facility.</td>
<td>$3,132,194</td>
</tr>
<tr>
<td>Pass</td>
<td>Category</td>
<td>Performing Provider</td>
<td>TPI</td>
<td>Project Unique ID Number</td>
<td>Project Title (include unique RHP project ID number for each project.)</td>
<td>Brief Project Description</td>
<td>Related Category 3 Outcome Measure(s) Unique Identifier</td>
<td>Related Category 3 Outcome Measure(s) Title</td>
<td>Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 &amp; 2 values)</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>---------------------</td>
<td>-----</td>
<td>--------------------------</td>
<td>-------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>--------------------------------------------------------</td>
<td>---------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>Rice Medical Center</td>
<td>212060201</td>
<td>212060201.2.3</td>
<td>3-1.2.1 - Rebuild self-management programs and wellness using evidence-based designs</td>
<td>Rice will develop and implement a program for diabetic care management support in its primary care clinics.</td>
<td>212060201.3.4</td>
<td>IT-1.10: Diabetes care: HbA1c peer control (7.0% – 9.0%) NQF 0044</td>
<td>$151,769</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Spindletop</td>
<td>96166002</td>
<td>096166002 1.1</td>
<td>3-7.7.1 - Implement other project to expand/establish rural health services and enhance client health information access portal. Client Health Information Access Portal</td>
<td>Spindletop will develop a web-based portal where secure client secured health information can be accessed by users with only basic computer skills. Select clients will be provided Wi-Fi enabled tablets so for the implementation of the new client information access portal.</td>
<td>096166002.5.2</td>
<td>IT-6.1 (4) Percent improvement over baseline of patient satisfaction scores - Patients getting timely healthcare information</td>
<td>$186,649</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>St. Joseph Medical Center</td>
<td>181706001</td>
<td>181706001.2.2</td>
<td>3-15.2.2 - Integrate primary and behavioral healthcare services: Design, implement and evaluate projects that provide integrated primary and behavioral healthcare services</td>
<td>This project will integrate primary care with the behavioral health care services Spindletop Center (&quot;Spindletop&quot;) provides in order to improve care and access to needed health services for the clients we serve.</td>
<td>181706001.3.1</td>
<td>IT-6.1 (1) Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information</td>
<td>$1,178,561</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>St. Joseph Medical Center</td>
<td>181706001</td>
<td>181706001.2.1</td>
<td>2.15.1.1 - Integrate Primary and Behavioral Health Care Services: Medical Psychiatry Unit</td>
<td>This proposed unit will meet the needs of adults (age 18 and above) who have a primary medical diagnosis with co-morbid psychiatric diagnoses. The unit will be certified to include two psychiatrists and social workers who will conduct the therapeutic interventions and make the discharge plans in collaboration with the attending physician.</td>
<td>181706001.3.2</td>
<td>IT-2.2: ED appropriate utilization-Reduce ED visits for behavioral health and substance abuse</td>
<td>$12,623,903</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>St. Luke’s Episcopal Hospital</td>
<td>227009003</td>
<td>227009003.2.2</td>
<td>2.2.2. - Apply evidence based care management model to patients identified as having high-risk health care needs: Identification and Treatment of Patients with Hepatitis C</td>
<td>The purpose of this project is to screen, identify, and provide high level care to individuals identified as having Hepatitis C using a distributed care model based on Project ECHOTM.</td>
<td>227009003.3.4</td>
<td>IT-5-2: Improvement in risk adjusted Potentially Preventable Complication rates</td>
<td>$2,216,899</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>St. Luke’s Episcopal Hospital</td>
<td>227009003</td>
<td>227009003.2.1</td>
<td>3.12.2.1 - Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions</td>
<td>The purpose of this project is to build a bridge from the acute inpatient setting to a stable primary care-based medical home for patients with congestive heart failure (CHF). The targeted population is that group of patients with CHF cared for in the SLEH acute inpatient setting for an index admission. The goal is to reduce rehospitalizations.</td>
<td>227009003.3.1</td>
<td>IT-5-2: Congestive Heart Failure 30 day readmission rate</td>
<td>$19,923,398</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>Tonsura Center</td>
<td>081527001</td>
<td>081527001.1.4</td>
<td>3.12.2.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas. Enhance service availability of appropriate levels of behavioral health care</td>
<td>Provide specialized behavioral health care services to the complex behavioral health population of children with disabilities of autism spectrum disorders and related conditions.</td>
<td>081527001.3.5</td>
<td>IT-9.2: ED appropriate utilization-Reduce ED visits for behavioral health and substance abuse</td>
<td>$4,449,821</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>Tonsura Center</td>
<td>081527001</td>
<td>081527001.1.1</td>
<td>3.12.2.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas. Enhance service availability of appropriate levels of behavioral health care</td>
<td>This project 1 project, 1.12.2. will provide specialized behavioral health care services to the complex behavioral health population of children with disabilities of autism spectrum disorders and related conditions.</td>
<td>081527001.3.1</td>
<td>IT-9.2: ED appropriate utilization-Reduce ED visits for behavioral health and substance abuse</td>
<td>$10,165,687</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>Tonsura Center</td>
<td>081527001</td>
<td>081527001.1.3</td>
<td>3-9.2. - Improve access to specialty care</td>
<td>Improve access to specialty care - Therapeutic Intervention for Infants and Toddlers at Risk</td>
<td>081527001.3.4</td>
<td>IT-11.1: Patient Centered Care satisfaction</td>
<td>$4,220,590</td>
</tr>
<tr>
<td>Pass</td>
<td>Category</td>
<td>Performing Provider</td>
<td>TPI</td>
<td>Project Unique ID Number</td>
<td>Project Title (include unique RHP project ID number for each project*)</td>
<td>Brief Project Description</td>
<td>Related Category 3 Outcome Measure(s)</td>
<td>Related Category 3 Outcome Measure(s)</td>
<td>Estimated Incentive Amount (DSRIP) for FYs 2-5 (Category 1 &amp; 2 values)</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>---------------------</td>
<td>-----</td>
<td>--------------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Texana Center</td>
<td>8152701</td>
<td>08152701.2.1</td>
<td>Region 3 Regional Healthcare Partnership Plan</td>
<td>2.13.1 – Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Behavioral Healthcare Crisis Center for six county area. Texana Center, the local mental health authority, proposes to meet a behavioral healthcare crisis center to serve a six county area (Fort Bend, Matagorda, Wharton, Colorado, Austin, and Waller Counties). The center will include an 8 bed 48-hour observation unit and a 14 bed crisis residential unit where individuals in crisis may go to be assessed and stabilized. The project number is 1.13.1 – Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.</td>
<td>IT-2.13 Other Admission Rate</td>
<td>$13,976,097</td>
<td>$5,627,436</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Texana Center</td>
<td>8152701</td>
<td>08152701.3.2</td>
<td>Region 3 Regional Healthcare Partnership Plan</td>
<td>1.9.2 Expand Specialty Access: Pediatric Rheumatology Care. Texana Center proposes to expand access to care in a Rheumatology Clinic.</td>
<td>IT-9.4 Other Outcome Improvement Target-Mental Health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers).</td>
<td>IT-9.4 Other Outcome Improvement Target-Mental Health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers).</td>
<td>$8,786,001</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Texas Children’s Hospital</td>
<td>139135109</td>
<td>139135109.1.1</td>
<td>Region 3 Regional Healthcare Partnership Plan</td>
<td>1.9.2 Improve access to specialty care: Expand Pediatric Neurology Clinic. Texas Children’s Hospital proposes to increase capacity for care in Pediatric Neurology Clinic.</td>
<td>IT-1.1 Third Next Available Appointment</td>
<td>IT-1.1 Third Next Available Appointment</td>
<td>IT-1.1 Third Next Available Appointment</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Texas Children’s Hospital</td>
<td>139135109</td>
<td>139135109.1.10</td>
<td>Region 3 Regional Healthcare Partnership Plan</td>
<td>1.9.2 Improve access to specialty care: Expand Pediatric Orthopedic Care. Texas Children’s Hospital proposes to expand access to pediatric orthopedic care, enabling patients to receive care in a more timely manner and reduce wait times for appointments.</td>
<td>IT-1.1 Third Next Available Appointment</td>
<td>IT-1.1 Third Next Available Appointment</td>
<td>IT-1.1 Third Next Available Appointment</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Texas Children’s Hospital</td>
<td>139135109</td>
<td>139135109.1.15</td>
<td>Region 3 Regional Healthcare Partnership Plan</td>
<td>1.9.2 Improve access to specialty care: Expand Women’s Mental Health Care. Texas Children’s Hospital will expand provider capacity, improve processes and increase availability of mental health services for women.</td>
<td>IT-1.1 Third Next Available Appointment</td>
<td>IT-1.1 Third Next Available Appointment</td>
<td>IT-1.1 Third Next Available Appointment</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Texas Children’s Hospital</td>
<td>139135109</td>
<td>139135109.1.36</td>
<td>Region 3 Regional Healthcare Partnership Plan</td>
<td>1.9.2 Improve access to specialty care: Pediatric Hematology/Oncology Care. Texas Children’s Hospital will increase capacity in the Pediatric Hematology/Oncology Clinic.</td>
<td>IT-9.4 Other Outcome Improvement Target-Mental Health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers).</td>
<td>IT-9.4 Other Outcome Improvement Target-Mental Health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers).</td>
<td>$8,115,596</td>
</tr>
</tbody>
</table>

*Project numbers are assigned based on project description and alignment with Regional Healthcare Partnership Plan goals.*
<table>
<thead>
<tr>
<th>Pass</th>
<th>Category</th>
<th>Performing Provider</th>
<th>TPI</th>
<th>Project Unique ID Number</th>
<th>Project Title (include unique RHP project ID number for each project)</th>
<th>Brief Project Description</th>
<th>Related Category 3 Outcome Measure(s) Unique Identifier</th>
<th>Related Category 3 Outcome Measure(s) Title</th>
<th>Estimated Incentive Amount (DSRIP) for FYs 3-5 (Category 1 &amp; 2 values)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>Texas Children’s Hospital</td>
<td>139135109</td>
<td>139135109.1.1</td>
<td>1.2.2 Expand Access to Specialty Care: Pediatric Cardiology Care</td>
<td>Specifically this project will increase capacity in our Cardiology Clinic. Through recruitment of additional highly specialized Pediatric Cardiologists with focused training in sub-specialized areas such as fetal cardiology, heart failure, adult congenital cardiology, pediatric electrophysiology, and pediatric interventional cardiology along with focused attention on creating provider productivity and increased efficiencies in patient throughput, this project will enable us to open clinics and increase appointment availability.</td>
<td>139135109.3.10</td>
<td>IT-5.1: Improved Cost Savings</td>
<td>$4,473,330</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>Texas Children’s Hospital</td>
<td>139135109</td>
<td>139135109.1.5</td>
<td>1.2.2 Expand Specialty Care Access: Pulmonology Pediatric Care</td>
<td>Texas Children’s Hospital proposes to increase capacity in the Pulmonology Clinic, which will improve access to care and ensure reduced appointment wait times.</td>
<td>139135109.3.15</td>
<td>IT-5.1: Improved Cost Savings</td>
<td>$4,415,709</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>Texas Children’s Hospital</td>
<td>139135109</td>
<td>139135109.1.6</td>
<td>1.2.2 Expand Access to Specialty Care: Pediatric Ophthalmology Care</td>
<td>Texas Children’s Hospital will increase capacity in the Ophthalmology Clinic to expand access and reduce appointment wait times.</td>
<td>139135109.3.16</td>
<td>IT-5.1: Improved Cost Savings</td>
<td>$5,027,511</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>Texas Children’s Hospital</td>
<td>139135109</td>
<td>139135109.1.7</td>
<td>1.2.2 Expand Pediatric Cardiometabolology Care</td>
<td>Texas Children’s Hospital proposes to increase access for children to pediatric subspecialty services in the gastroenterology, hepatology and nutrition (GHN) clinic.</td>
<td>139135109.3.19</td>
<td>IT-5.1: Improved Cost Savings</td>
<td>$8,786,004</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>Texas Children’s Hospital</td>
<td>139135109</td>
<td>139135109.1.8</td>
<td>1.2.2 Expand Specialty Care: Capacity Diabetes Endocrinology Pediatric Care</td>
<td>Texas Children’s Hospital proposes to expand access to pediatric care in diabetes and endocrinology.</td>
<td>139135109.3.22</td>
<td>IT-5.1: Improved Cost Savings</td>
<td>$8,786,005</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>Texas Children’s Hospital</td>
<td>139135109</td>
<td>139135109.1.9</td>
<td>1.2.2 Improve access to specialty care: Expanded Child Abuse Care</td>
<td>Texas Children’s Hospital proposes to establish a specialty care program for children who have experienced abuse or neglect.</td>
<td>139135109.3.25</td>
<td>IT-10.1: Quality of Life</td>
<td>$2,046,964</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>Texas Children’s Hospital</td>
<td>139135109</td>
<td>139135109.2.1</td>
<td>2.1.4 Expand Medical Homes for Transition Population</td>
<td>Texas Children’s Health will establish a patient centered medical home for medically fragile children in order to provide prospective care coordination, chronic disease management, and a multidisciplinary approach that educates patients and providers on appropriate transition processes.</td>
<td>139135109.3.43</td>
<td>IT-6.1: Percent improvement over baseline of patient satisfaction scores</td>
<td>$6,131,493</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>The Methodist Hospital</td>
<td>137940703</td>
<td>137940703.2.1</td>
<td>2.1.1 - Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Implement Care Transition Coordination</td>
<td>The Methodist Hospital will create a program preventing behavioral health readmissions by Implementing care transition coordination.</td>
<td>137940703.3.1</td>
<td>IT-5.18: Follow-Up After Hospitalization for Mental Illness- NQF 0176235</td>
<td>$13,443,321</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>The Methodist Willowbrook Hospital</td>
<td>140713201</td>
<td>140713201.2.1</td>
<td>2.1.1 - Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Implement Care Transition Coordination</td>
<td>Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Implement Care Transition Coordination</td>
<td>140713201.3.1</td>
<td>IT-5.18: Follow-Up After Hospitalization for Mental Illness- NQF 0176236 (Opioid/Substance Use)</td>
<td>$4,939,422</td>
</tr>
<tr>
<td>Pass</td>
<td>Category</td>
<td>Performing Provider</td>
<td>TPI</td>
<td>Project Unique ID Number</td>
<td>Project Title (include unique RHP project ID number for each project)</td>
<td>Brief Project Description</td>
<td>Estimated Incentive Amount (DSRIP) for RVs 2-5 (Category 1 &amp; 2 values)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>---------------------</td>
<td>-----</td>
<td>--------------------------</td>
<td>-------------------------------------------------------------</td>
<td>---------------------------</td>
<td>-------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>The University of Texas MD Anderson Cancer Center</td>
<td>112672402</td>
<td>112672402.2.5</td>
<td>2.7.2 - Implement innovative evidence-based strategies to reduce tobacco use - Replacing Ask Advisive Connect (AAC) in Federally Qualified Health Centers</td>
<td>The University of Texas MD Anderson Cancer Center (MD Anderson), in partnership with The Rose, a non-profit breast organization, and the Houston Department of Human and Health Services, will expand Project VALET Smoking Cessation - Enroll &amp; Treat to a new site in Tomball, TX.</td>
<td>$4,887,399</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>The University of Texas MD Anderson Cancer Center</td>
<td>112672402</td>
<td>112672402.2.1</td>
<td>2.7.1 - Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use) using: Colonoscopy CEG (CRC) screening program for low-income residents of RHP3</td>
<td>We propose to implement a FIT-Flu program in RHP3 targeting low-income and uninsured populations.</td>
<td>$8,773,922</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>The University of Texas MD Anderson Cancer Center</td>
<td>112672402</td>
<td>112672402.2.3</td>
<td>2.7.2 - Implement innovative evidence-based strategies to reduce tobacco use - Multimodal Tool and Community Engagement for Youth Early Tobacco Prevention and Cessation</td>
<td>Tobacco is the number one preventable cause of death from cancer and other diseases. Nearly all tobacco use begins during the teenage years. Low-income, uninsured youth are at highest risk for becoming tobacco users.</td>
<td>$10,995,450</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Tomball Regional Medical Center</td>
<td>288525001</td>
<td>288525001.1.1</td>
<td>1.2 - Expand existing primary care capacity: Expand primary care access for uninsured populations within and around Tomball</td>
<td>Tomball Regional Medical Center (TRMC), the area’s sole service hospital, is proposing a Category 1 DSRIP project to expand primary care access for the uninsured population within and around The City of Tomball.</td>
<td>$3,526,434</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>University of Texas Health Science Center</td>
<td>118100101</td>
<td>118100101.1.1</td>
<td>1.2 - Expand Primary Care Capacity: Expand Primary Care Capacity at UT Physicians Clinics</td>
<td>UT Physicians will expand primary care capacity at each of its 5 existing standalone facilities. The goal of the current proposal is to adapt, implement, and evaluate an evidence-based, cell phone-delivered smoking cessation treatment program targeted to low-income and uninsured populations at the University of Texas Medical School - Houston</td>
<td>$897,183</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>University of Texas Health Science Center</td>
<td>118100101</td>
<td>118100101.1.10</td>
<td>1.9.2 - Expand Specialty Care Services to New North Harris County Primary Care Clinic</td>
<td>UT Physicians will expand specialty care services in Tomball, TX. The primary care clinic will expand to provide care for patients with cardiovascular conditions (NCQA-Standalone measure)</td>
<td>$20,181,182</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>University of Texas Health Science Center</td>
<td>118100101</td>
<td>118100101.1.2</td>
<td>1.3.1 Increase Training of Primary Care Workforce: A2 UT Health - Regional Academy for Translational Medicine and UT Health Academy for Patient Quality and Safety</td>
<td>UT Physicians will recruit specialists for the new primary care clinic in Tomball, TX. This will further expand the specialty care services in Tomball, TX.</td>
<td>$11,579,767</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Regional Healthcare Partnership Plan**

**Region 3**

**27**
1. University of Texas Health Science Center
   - TPI: 111811001
   - Project Unique ID Number: 11180000.3.3
   - Related Category 3 Outcome Measure(s): IT-1.5 (HEDIS 2012) Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) for a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure
   - Estimated Incentive Amount (DSRIP) for FYs 2-5 ($Category 1 & 2 values): $11,377,188

2. University of Texas Health Science Center
   - TPI: 111811001
   - Project Unique ID Number: 11180000.3.4
   - Related Category 3 Outcome Measure(s): IT-1.7 Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Standalone measure)
   - Estimated Incentive Amount (DSRIP) for FYs 2-5 ($Category 1 & 2 values): $7,987,519

3. University of Texas Health Science Center
   - TPI: 111811001
   - Project Unique ID Number: 11180000.3.5
   - Related Category 3 Outcome Measure(s): IT-2.10 Flu and pneumonia (Admission rate) (NCQA-HEDIS 2012, NQF 0018) (Standalone measure)
   - Estimated Incentive Amount (DSRIP) for FYs 2-5 ($Category 1 & 2 values): $13,982,383

4. University of Texas Health Science Center
   - TPI: 111811001
   - Project Unique ID Number: 11180000.3.6
   - Related Category 3 Outcome Measure(s): IT-1.6.1 Third next available appointment (Non-standalone measure)
   - Estimated Incentive Amount (DSRIP) for FYs 2-5 ($Category 1 & 2 values): $15,215,797

5. University of Texas Health Science Center
   - TPI: 111811001
   - Project Unique ID Number: 11180000.3.7
   - Related Category 3 Outcome Measure(s): IT-4.8 Sepsis mortality (Standalone measure)
   - Estimated Incentive Amount (DSRIP) for FYs 2-5 ($Category 1 & 2 values): $7,987,519

6. University of Texas Health Science Center
   - TPI: 111811001
   - Project Unique ID Number: 11180000.3.8
   - Related Category 3 Outcome Measure(s): IT-2.10 Fig.2, 2.10, Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) for a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure
   - Estimated Incentive Amount (DSRIP) for FYs 2-5 ($Category 1 & 2 values): $13,982,383

7. University of Texas Health Science Center
   - TPI: 111811001
   - Project Unique ID Number: 11180000.3.9
   - Related Category 3 Outcome Measure(s): IT-2.10 Fig.2, 2.10, Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) for a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure
   - Estimated Incentive Amount (DSRIP) for FYs 2-5 ($Category 1 & 2 values): $13,982,383

8. University of Texas Health Science Center
   - TPI: 111811001
   - Project Unique ID Number: 11180000.2.1
   - Related Category 3 Outcome Measure(s): IT-1.5 (HEDIS 2012) Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) for a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure
   - Estimated Incentive Amount (DSRIP) for FYs 2-5 ($Category 1 & 2 values): $11,377,188

9. University of Texas Health Science Center
   - TPI: 111811001
   - Project Unique ID Number: 11180000.2.2
   - Related Category 3 Outcome Measure(s): IT-1.5 (HEDIS 2012) Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) for a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure
   - Estimated Incentive Amount (DSRIP) for FYs 2-5 ($Category 1 & 2 values): $11,377,188
<table>
<thead>
<tr>
<th>Pass</th>
<th>Category</th>
<th>Performing Provider</th>
<th>TPI</th>
<th>Project Unique ID Number</th>
<th>Project Title (include unique RHP project ID number for each project)</th>
<th>Brief Project Description</th>
<th>Related Category 1 Outcome Measure(s) Unique Identifier</th>
<th>Related Category 2 Outcome Measure(s) Title</th>
<th>Related Category 3 Outcome Measure(s)</th>
<th>Estimated Incentive Amount (DSRIP) for FYs 2-5 (Category 1 &amp; 2 values)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>University of Texas Health Science Center</td>
<td>11181001</td>
<td>011810001.2,2</td>
<td>2.1.1 Establish a Patient Care Navigation Program: A4 UTHSC/UTH Regional Patient Navigation</td>
<td>The project will entail identifying patients admitted to any adult ICU at Memorial Hermann Hospital-TMC who are at high risk of death in or soon after hospitalization. In collaboration with the primary clinical team, those patients will receive a palliative care consultation to supplement their clinical therapy and assist in determination of goals of care which may include transitioning the patients from acute hospital care into home care, hospice or a skilled nursing facility.</td>
<td>11181001.3.19</td>
<td>IT-5.1. Pain assessment (NQF-1637) (Non-standalone measure)</td>
<td>$13,134,966</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>University of Texas Health Science Center</td>
<td>11181001</td>
<td>011810001.2,3</td>
<td>2.1.1.1 - Patient-Centered Medication Management Program - Conduct Medical Management UTHealth, UT Physicians</td>
<td>UT Physicians will implement a patient-centered medication management program. Using the Allscripts analytics tool, staff will identify patients at high risk for developing complications and adverse effects from potential interactions, or non-compliance. Related patient information in the EHR will be used to review the complete medication regimen and history to assess compliance.</td>
<td>11181001.3.2</td>
<td>IT-5.2. Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) - angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non-standalone measure)</td>
<td>$7,203,047</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>University of Texas Health Science Center</td>
<td>11181001</td>
<td>011810001.2,6</td>
<td>2.1.2.2 Implement/Expand Care Transitions Program: A1 UTHSC/UTH General Care Transitions</td>
<td>UT Physicians will implement a discharge planning program and post discharge support program that assures that patients have an appointment for follow-up with an appropriate physician(s) prior to leaving the hospital, understand their discharge medications and other instructions, and are followed up post discharge, particularly those at risk of readmitting acute care services within 30-60 days.</td>
<td>11181001.3.25</td>
<td>IT-5.3 Blood 30 day readmission rate (Standalone measure)</td>
<td>$13,861,840</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>University of Texas Health Science Center</td>
<td>11181001</td>
<td>011810001.2,7</td>
<td>2.1.5.1 - Integrate Primary and Behavioral Health Care Services: Conduct Integrated Adult Primary and Behavioral Health Care Services</td>
<td>UT Health will design, implement and evaluate a project that will integrate primary and behavioral health care services within UT Physicians clinics to achieve a close collaboration in a partly integrated system of care (Level P1).</td>
<td>11181001.3.27</td>
<td>IT-5.6. Depression management: Screening and Treatment Plan for Clinical Depression (JQQR 2011, v134 ) (Non-standalone measure)</td>
<td>$13,134,946</td>
<td></td>
</tr>
</tbody>
</table>

**Estimated Incentive Amount (DSRIP) for FYs 2-5 (Category 1 & 2 values):**

- $11,481,132
- $13,711,258
- $6,567,493
- $7,203,047
- $13,861,840
- $13,134,946
<table>
<thead>
<tr>
<th>Pass</th>
<th>Category</th>
<th>Performing Provider</th>
<th>TPI</th>
<th>Project Unique ID Number</th>
<th>Project Title (include unique RHP project ID number for each project)</th>
<th>Brief Project Description</th>
<th>Estimated Incentive Amount (DSRIP) for PEs 2-5 (Category 1 &amp; 2 values)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>Region 3</td>
<td>University of Texas Health Science Center</td>
<td>1118100101</td>
<td>1118100101.2.8</td>
<td>2.1.1.1 - Integrate Primary and Behavioral Health Care Services: Integrated Primary and Behavioral Health Care Services for Children and Adolescents</td>
<td>UT Health will design, implement and evaluate a project that will integrate primary and behavioral health care services for children and adolescents within UT Physicians 4逾期 clinics and the pediatric specialty clinic in the Texas Medical Center in order to achieve a close collaboration in a partly integrated system of care (Level IV). The project will enroll and place a pediatric behavioral health provider in the 4 primary care settings and the 1 pediatric specialty care clinic to provide children and adolescents with behavioral health services at their usual source of healthcare and will facilitate the coordination of care involving both primary and behavioral health.</td>
<td>$16,416,710</td>
</tr>
<tr>
<td>1</td>
<td>Region 3</td>
<td>Memorial Hermann Hospital</td>
<td>137805107</td>
<td>137805107.1.1</td>
<td>1.1.1 Establish more primary care clinics: Physician Network Development</td>
<td>Memorial will expand the network of primary care physicians in the community. Moreover, this expansion will strengthen an integrated health care system and play a key role in implementing disease management programs. A greater focus on primary care will be crucial to the success of an integrated health care system.</td>
<td>$16,253,190</td>
</tr>
<tr>
<td>2</td>
<td>Region 3</td>
<td>Memorial Hermann Hospital</td>
<td>137805107</td>
<td>137805107.1.2</td>
<td>1.3.3 Develop and Implement Crisis Stabilization Services</td>
<td>Memorial’s proposal is to develop a crisis stabilization clinic that better identifies people with behavioral health needs, responds to those needs and links persons with the most appropriate level of care. The clinic will be staffed with a nurse practitioner, social worker and other patient care staff to provide an outpatient emergency appointment for patients with no immediate access for mental health care.</td>
<td>$16,559,654</td>
</tr>
<tr>
<td>1</td>
<td>Region 3</td>
<td>Memorial Hermann Hospital</td>
<td>137805107</td>
<td>137805107.1.3</td>
<td>1.1.1- Establish Mass Primary Care Clinics: Pediatric Clinic Expansion - North Harris County Pediatric Clinic</td>
<td>Memorial will establish the North Harris County Pediatric Clinic, which will provide primary care for pediatric patients in an area of Harris County that is between Cypress-Fairbanks and FM 1960 to the north, Tomball Parkway to the west, Highway 99 to the east and Mason Road to the south. The clinic will be located in an area of Harris County that is between Cypress Pkwy and FM 1960 to the north, Tomball Parkway to the west, Highway 99 to the east and Mason Road to the south. The clinic will be located in an area of Harris County that is between Cypress Pkwy and FM 1960 to the north, Tomball Parkway to the west, Highway 99 to the east and Mason Road to the south. The clinic will be located in an area of Harris County that is between Cypress Pkwy and FM 1960 to the north, Tomball Parkway to the west, Highway 99 to the east and Mason Road to the south. The clinic will be located in an area of Harris County that is between Cypress Pkwy and FM 1960 to the north, Tomball Parkway to the west, Highway 99 to the east and Mason Road to the south. The clinic will be located in an area of Harris County that is between Cypress Pkwy and FM 1960 to the north, Tomball Parkway to the west, Highway 99 to the east and Mason Road to the south. The clinic will be located in an area of Harris County that is between Cypress Pkwy and FM 1960 to the north, Tomball Parkway to the west, Highway 99 to the east and Mason Road to the south.</td>
<td>$17,294,232</td>
</tr>
<tr>
<td>3</td>
<td>Region 3</td>
<td>Memorial Hermann Hospital</td>
<td>137805107</td>
<td>137805107.1.4</td>
<td>1.1.1- Establish Mass Primary Care Clinics: Pediatric Clinic Expansion - Houston Ship Channel South Pediatric Clinic</td>
<td>Memorial will establish the Houston Ship Channel South Pediatric Clinic, which will provide primary care for pediatric patients in an area of Harris County that is between the Houston Ship Channel to the north, S305 to the west, Beltway 85 to the south, and Belvedere Rd to the east. The clinic will have access to primary care in the community. Moreover, this expansion will strengthen an integrated health care system and play a key role in implementing disease management programs. A greater focus on primary care will be crucial to the success of an integrated health care system.</td>
<td>$17,925,714</td>
</tr>
<tr>
<td>1</td>
<td>Region 3</td>
<td>Memorial Hermann Hospital</td>
<td>137805107</td>
<td>137805107.1.5</td>
<td>1.1.1 Establish Mass Primary Care Clinics: Pediatric Clinic Expansion - Houston Ship Channel North Pediatric Clinic</td>
<td>Memorial will establish the Houston Ship Channel North Pediatric Clinic, which will provide primary care for pediatric patients in an area of Harris County that is between Beltway 85 to the north, S305 to the west, Beltway 85 to the south, and Baytown to the east. The clinic will have access to primary care in the community. Moreover, this expansion will strengthen an integrated health care system and play a key role in implementing disease management programs. A greater focus on primary care will be crucial to the success of an integrated health care system.</td>
<td>$17,294,232</td>
</tr>
<tr>
<td>Pass</td>
<td>Category</td>
<td>Performing Provider</td>
<td>TPI</td>
<td>Project Unique ID Number</td>
<td>Project Title (include unique RHP project ID number for each project)</td>
<td>Brief Project Description</td>
<td>Related Category 3 Outcome Measure(s)</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>---------------------</td>
<td>-----</td>
<td>--------------------------</td>
<td>-------------------------------------------------</td>
<td>-----------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>Memorial Hermann Hospital</td>
<td>137850107</td>
<td>020834001.1.1</td>
<td>1.1.1 Establish more primary care clinics: Primary Care Expansion School-Based Health</td>
<td>Increase the number of school based primary care sites in low income communities for people with limited access to the community. Memorial Hermann initially proposes to offer this service to patients in the following zip codes: 77090, 77098, and 77012.</td>
<td>IT-9.2 Patient Statisfaction- NQF (Category 1 &amp; 2 measures)</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>Memorial Hermann Hospital</td>
<td>137850107</td>
<td>020834001.1.2</td>
<td>1.2 24 Hour Nurse Triage Line</td>
<td>Implement a region-wide 24 Hour Nurse Triage Line, seven days a week that will assist patients residing in the region, who are considering an ER visit, in determining what level of care they need to access and connect them to an appropriate source.</td>
<td>IT-9.2 Ed Appropriate Utilization</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>Memorial Hermann-Northwest</td>
<td>137850107</td>
<td>020834001.3.3</td>
<td>1.12.2 Home Health Psych Services</td>
<td>Memorial Hermann proposes to expand home health services to include psychiatric services. The program would include specialized training and certifications for nurses and the addition of social work services to link clients to additional community care programs.</td>
<td>IT-9.4 Other Outcome Improvement Target - ED Appropriate Utilization</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>Memorial Hermann-Northwest</td>
<td>137850107</td>
<td>020834001.3.4</td>
<td>1.1.2 Expand Existing Primary Care Capacity: Convenient Care Centers</td>
<td>Create neighborhood centers that integrate all ambulatory services in a highly coordinated, efficient and accessible manner (imaging, emergency care, Primary Care, Specialty Care, Lab, Therapy, and Pharmacy for the Greater Houston Metropolitan Statistical area targeting pediatric and adult primary care patients.</td>
<td>IT-9.10 Diabetes Care: HbA1c poor control</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>Memorial Hermann-Northwest</td>
<td>137850107</td>
<td>020834001.3.5</td>
<td>1.1-1 Establish More Primary Care Clinics: Pediatric Clinic Expansion Northwest Houston Pediatric Clinic</td>
<td>In this project, Memorial will establish the Northwest Houston Pediatric Clinic, which will provide primary care for pediatric patients in an area of Harris County that is between Halls Bayou to the north, Beltway 8 to the west, 5-10W and 10W to the south, and the Hardy Toll Road to the east. Memorial has defined the service area for this clinic as a priority area for pediatric services, because it contains 14 of the 81 census tracts that make up the top 1% of all census tracts in Harris County with the greatest number of people below the age of 18 that are living below the federal poverty level (FPL).</td>
<td>IT-1.3 Third next available appointment (Non-vaccines measure)</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>Memorial Hermann-Northwest</td>
<td>137850107</td>
<td>020834001.3.6</td>
<td>2.2.2 Psych Response Team - Case Management</td>
<td>Provide a 24/7 liaison to act as an adjunct to the Psych Response Team to provide more intensive case management of “post-discharge” behavioral health patients to reduce readmission and increase compliance with follow-up.</td>
<td>IT-9.8 Behavioral Health/Substance Abuse (BH/SA) 30 day readmission rate</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>Memorial Hermann-Northwest</td>
<td>137850107</td>
<td>020834001.3.7</td>
<td>2.9.2 “Other” project option: MHMD Care Management</td>
<td>Implementation of comprehensive care management infrastructure across the continuum of care for populations contributed to the MHMD Clinical Integrated Network of Patient Centered Medical Home (PCMH) practices, embedding care managers into those practices, tracking patient compliance with referral patterns and assigning Case Managers (CMEs) to emergency department, inpatient discharges, and high risk patients.</td>
<td>IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction</td>
</tr>
<tr>
<td>Pass</td>
<td>Category</td>
<td>Performing Provider</td>
<td>TPI</td>
<td>Project Unique ID Number</td>
<td>Project Title (include unique RHP project ID number for each project)</td>
<td>Brief Project Description</td>
<td>Related Category 3 Outcome Measure(s) Unique Identifier</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>---------------------</td>
<td>-----</td>
<td>--------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>HCA-West Houston Medical Center</td>
<td>094187402</td>
<td>094187402.2.1</td>
<td>2.9.1 Provide navigation services to targeted patients who are at high risk of disconnection from institutionalized health care: Expand Senior Care Capacity at West Houston</td>
<td>Through implementing this project, HCA intends to improve patient throughput, overall experience and quality of care for geriatric patients. Geriatric patients will benefit from the dedicated care designed to meet the needs of patients greater than 65 years of age who live in West Houston’s primary and secondary zip codes located in Harris County. This dedicated care includes unique components to address both environmental and clinical service needs. Specifically, HCA will create a designated “Senior Care Entrance” at the hospital and assign special hospital beds which are designed to accommodate the geriatric population. Additionally, HCA will train and maintain a Senior Care Coordinator dedicated to overseeing protocol-driven geriatric care, which will be developed with input from facility geriatricians, and close communication with local SNFs, LTACs, and nursing homes to assure solid continuity of care. The Senior Care Coordinator will assist seniors in managing their appointments, maintaining their individual healthcare regimens, and accessing available support through the hospital and the community.</td>
<td>094187402.3.1 IT-3.1 All cause 30 day readmission rate (for patients enrolled in care navigation program)</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>HCA-Bayshore Medical Center</td>
<td>020817501</td>
<td>020817501.1.1</td>
<td>1.1.2 Expand Primary Care Capacity: Expand Obstetrical and Gynecological Care Capacity in East Houston</td>
<td>HCA will expand the availability of obstetrical services through existing OB Clinics located in the service areas of Bayshore Medical Center and East Houston Regional Medical Center. HCA will do this by recruiting new OB/GYNs to the East Houston area to help with a growing community need. East Houston is an area projected to grow by 8.6% over the next five years and has a current deficit of 20.6 OB/GYNs according to a needs assessment completed in October of 2011.</td>
<td>020817501.3.1 IT-8.2 Percentage of Low Birth Weight Babies</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>HCA-Bayshore Medical Center</td>
<td>020817501</td>
<td>020817501.1.2</td>
<td>1.7.1 Implement Telemedicine program to provide or expand specialist referral services in an area identified as needed to the region: Behavioral Health Telemedicine Services</td>
<td>HCA intends to expand its existing telemedicine program to include a 24/7 tele-psychiatry program in its Bayshore Emergency Department (ED), as well as implementing telemedicine capabilities in the EDs at West Houston Medical Center, East Houston Regional Medical Center (a campus of Bayshore), Clear Lake Regional Medical Center and Woman’s Hospital.</td>
<td>020817501.3.2 IT3.8 Behavioral Health/Substance Abuse 30 day readmission rate</td>
</tr>
</tbody>
</table>
Section III. Community Needs Assessment
REGION OVERVIEW
The Southeast Texas Regional Healthcare Partnership is the largest Regional Health Partnership (RHP) in Texas and includes more than 4.8 million people who receive healthcare through one of the most comprehensive healthcare systems in the world. While each county has a distinctive population and health care infrastructure designed to serve the local community, patterns of health care utilization and physician referrals commonly cross county lines, providing access to an extended network of providers and organizations positioned to serve the diverse population of this region.

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

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

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

---

4 U.S. Census, American Community Survey 2008-2010
6 Austin County Community Plan.
7 County Health Rankings and Roadmaps, County Health Rankings 2012.
The community is served by a single acute care hospital, Memorial Medical Center located in Port Lavaca. This public hospital provided more than 10,000 emergency room visits and 26,000 outpatient visits in 2010, and more than 1,300 inpatient admissions. The county is a designated MUA and has applied to be a HPSA for primary care, dental and mental health services, and has no practicing psychiatrists. Behavioral health services are provided primarily by Gulf Bend MHMR Center, which serves residents from seven counties, the majority of which (62%) live in Victoria county and have an annual income of $11,000. With a median household income of $42,745, Calhoun County has the highest percentage of children living in poverty (30.7%) of all counties in the Region. Due to its proximity about halfway between Houston and Corpus Christi, Calhoun County residents often must travel between 80 and 150 miles to these larger communities for specialty care. The county’s overall health ranking is number 49 out of 221 Texas counties with contributing factors of high adult obesity rate (30%); high teen birth rate (81 per 1,000 female teens); a high number rate of sexually transmitted infections; and a high uninsured population (28%).

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

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

---

8 Texas Department of State Health Services, 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospital Tracking Database.
9 Health Resources and Services Administration, August 2012, and Texas Medical Board, Physician Demographics by County and Specialty, January 2012.
11 County Health Rankings 2012.
12 Ibid
13 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospital Tracking Database.
14 Health Resources and Services Administration, August 2012, and Texas Medical Board, Physician Demographics by County and Specialty, January 2012.
15 County Health Rankings
16 Texas Department of State Health Services, Health Facts Profile 2009
includes three small incorporated communities (Columbus, Eagle Lake, and Weimar) with approximately 9,588 residents, and 18 rural, unincorporated communities with a total of approximately 11,213 residents. The county has a median household income of $40,930. An estimated 22% of the population has no health insurance. The area is served by three acute care hospitals, Colorado-Fayette Medical Center, Columbus Community Hospital and Rice Medical Center. Together these facilities accounted for 10,241 emergency room visits, 101,821 outpatient visits, and 9,012 inpatient admissions, and provided more than $5 million in uncompensated care in 2010. Behavioral health and intellectual disability services are available to eligible residents through Texana Center. The county is a designated HPSA for primary care, dental and mental health services. The county’s health care ranking is 132 of 221 counties with contributing factors of insufficient access to care; high adult obesity rates (29%); a high number of poor physical (5.6 per 30 days) and mental (4.6 per 30 days) health days reported by residents; a high rate of sexually transmitted infections; and a high uninsured rate.

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

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

17 Colorado County, Colorado County Community Plan 2011-2012.
18 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospital Tracking Database
19 County Health Rankings
20 U.S. Census Bureau, 2010 U.S. Census.
21 U.S. Department of Health and Human Services, Healthcare Resources and Services Administration.
22 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospital Tracking Database
23 County Health Rankings, 2012 and Texas Department of State Health Services, Health Facts Profile 2009.
24 U.S. Census Bureau, 2010 U.S. Census and Coalition for the Homeless of Houston/Harris County, Houston/Harris County 2010 Homeless County & Survey and 2011 Homeless Enumeration Count.
25 U.S. Census Bureau and Texas State Data Center, 2010 U.S. Census.
and 21% born in Asia.\textsuperscript{26} Median household income is the third highest in the region at $50,437. County residents are served by 67 acute care hospitals which collectively provided more than $3.3 billion in uncompensated care in 2010 and reported more than 7.6 million outpatient visits, 476,000 inpatient stays, and 1.44 million emergency room visits.\textsuperscript{27} Behavioral health care services are available through the county’s community mental health center, the Mental Health and Mental Retardation Authority of Harris County as well as other healthcare providers. Harris County is also the location of The Texas Medical Center, the largest medical complex in the world with a total annual budget of $14 billion for the 52 not-for-profit member institutions. But despite its large health care infrastructure, the county is a designated HPSA for primary, dental and mental health care and struggles to meet the complex needs of a diverse population that is constantly growing. Based on health factors, the county is ranked 160 of 221 counties, due in part to insufficient access to care; high rates of adult obesity (29%), sexually transmitted infections, tuberculosis, and excessive drinking (17%). The county also has a high rate of teen births and low birth weight babies, and low rate of prenatal care in the first trimester (51%).\textsuperscript{28} Other health care challenges include a high prevalence of behavioral health issues and needs, an inadequate number of primary care and specialty service providers to meet significant demands, and development of a comprehensive region-wide care coordination system that manages patient needs in the most appropriate setting.

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

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

\textsuperscript{26} U.S. Census Bureau, Statistical Abstract of the United States: 2011.
\textsuperscript{27} 2010 Cooperative DSHA/AHA/THA Annual Survey of Hospitals and Hospital Tracking Database; eight hospitals in Harris County were not included in the survey data, but are included in the total count.
\textsuperscript{28} County Health Rankings 2012, and Health Facts Profile 2009
\textsuperscript{29} U.S. Census Bureau, 2010 Census.
\textsuperscript{30} 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospitals Tracking Database
\textsuperscript{31} County Health Rankings 2012.
county has a median household income of $46,313 and the highest percentage of residents living in poverty (20.4%) among all counties in within the region. The county also reflects a younger population, with a median age of 31.7 years, Residents needing hospital services obtains care in surrounding counties; there are no acute care hospitals within the county. Behavioral health and intellectual disability services are available to qualified residents through the Texana Center. The county is a designated HPSA for primary, dental and mental health care. In the County Health Rankings, Waller County is number 112 of 221 counties with contributing factors of a high proportion of poor mental health days (5.5 per 30 day period); a high level of adult obesity (32%), high rate of sexually transmitted infections; high teen birth rate; poor access to primary care; high rate of uninsured.

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

**Region Demographics and Insurance Coverage**

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

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

---

32 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospitals Tracking Database.
33 County Health Rankings 2012 and Health Facts Profile 2009.
34 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospitals Tracking Database.
35 Health Resources and Services Administration, August 2012.
36 Texas Medical Board, 2012.
37 County Health Rankings 2012 and Health Facts Profile 2009.
Table 2: 2015 Population Predictions

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


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

Table 3: Income and Poverty Status by County – 2010

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

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

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

Table 4: Educational Attainment by Age
2008-2010 Average

<table>
<thead>
<tr>
<th>County</th>
<th>Age 18-24 Years</th>
<th>Age 25 and Over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Less than High School</td>
<td>High School Graduate</td>
</tr>
<tr>
<td>Austin</td>
<td>12.3%</td>
<td>87.7%</td>
</tr>
<tr>
<td>Calhoun</td>
<td>22.4%</td>
<td>77.6%</td>
</tr>
<tr>
<td>Chambers</td>
<td>24.1%</td>
<td>75.5%</td>
</tr>
<tr>
<td>Colorado</td>
<td>26.2%</td>
<td>73.8%</td>
</tr>
<tr>
<td>Fort Bend</td>
<td>17.0%</td>
<td>83.0%</td>
</tr>
<tr>
<td>Harris</td>
<td>24.2%</td>
<td>75.8%</td>
</tr>
<tr>
<td>Matagorda</td>
<td>33.9%</td>
<td>66.1%</td>
</tr>
<tr>
<td>Waller</td>
<td>8.3%</td>
<td>91.7%</td>
</tr>
<tr>
<td>Wharton</td>
<td>24.5%</td>
<td>75.5%</td>
</tr>
</tbody>
</table>

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

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

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

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

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

### Table 5: Workforce Status of People Aged 16 and Over 2008-2010

<table>
<thead>
<tr>
<th>County</th>
<th>Total Population</th>
<th>Percentage In Labor Force</th>
<th>Percentage Employed</th>
<th>Percentage Unemployed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin</td>
<td>21,873</td>
<td>62.9%</td>
<td>58.8%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Calhoun</td>
<td>16,357</td>
<td>60.0%</td>
<td>54.0%</td>
<td>11.3%</td>
</tr>
<tr>
<td>Chambers</td>
<td>25,061</td>
<td>66.2%</td>
<td>62.0%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Colorado</td>
<td>16,424</td>
<td>59.7%</td>
<td>56.7%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Fort Bend</td>
<td>418,152</td>
<td>68.6%</td>
<td>64.9%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Harris</td>
<td>3,019,173</td>
<td>69.1%</td>
<td>63.8%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Matagorda</td>
<td>28,202</td>
<td>61.7%</td>
<td>53.5%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Waller</td>
<td>32,986</td>
<td>64.4%</td>
<td>59.6%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Wharton</td>
<td>31,087</td>
<td>65.0%</td>
<td>60.2%</td>
<td>7.4%</td>
</tr>
</tbody>
</table>

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

### Health Insurance Status

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

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

---

41 Kaiser Family Foundation. *The Uninsured: A Primer, October 2011.*
42 University School of Public Health, *Houston Hospitals Emergency Department Use Study, January 1, 2009 through December 31, 2009.* University of Texas Health Science Center at Houston, May, 2011.
Table 6: Health Insurance Status – 3 Year Estimate, 2008-2010

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


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

Table 7: Federal Initiatives

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

Regional Healthcare Partnership Plan  Region 3  42
Description of Regional Health System and Challenges

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

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

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

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

43 Greater Houston Partnership, Partnership Research, 2011.
44 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospitals Tracking Database
45 Texas Medical Board, Physician Demographics by County and Specialty, January 2012.
Table 8: Physicians by County and Specialty – January 2012

<table>
<thead>
<tr>
<th>County</th>
<th>General Practice, Family Medicine</th>
<th>Pediatrics</th>
<th>Internal Medicine</th>
<th>OB/GYN</th>
<th>General &amp; Specialty Surgery</th>
<th>Psychiatry</th>
<th>Total Physicians - All Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Calhoun</td>
<td>7</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Chambers</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Colorado</td>
<td>13</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>29</td>
</tr>
<tr>
<td>Fort Bend</td>
<td>148</td>
<td>82</td>
<td>89</td>
<td>47</td>
<td>73</td>
<td>26</td>
<td>707</td>
</tr>
<tr>
<td>Harris</td>
<td>1,150</td>
<td>1,187</td>
<td>1,549</td>
<td>484</td>
<td>1,037</td>
<td>461</td>
<td>11,425</td>
</tr>
<tr>
<td>Matagorda</td>
<td>7</td>
<td>4</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>38</td>
</tr>
<tr>
<td>Waller</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Wharton</td>
<td>14</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>0</td>
<td>49</td>
</tr>
<tr>
<td>Total:</td>
<td>1,350</td>
<td>1,2823</td>
<td>1,660</td>
<td>544</td>
<td>1,123</td>
<td>489</td>
<td>12,286</td>
</tr>
</tbody>
</table>

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

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

---

46 Houston Health Services Research Collaborative for the Health of Houston Initiative, “Harris County Health Care Safety Net: Where We Stand 2010.”
47 Ibid.
49 Ibid.
based clinics, one dental center, a health care program for the homeless, a specialty center for people with HIV/AIDS, and five mobile health facilities. Staff for the District hospitals and clinics is provided through a contractual arrangement with the Baylor College of Medicine and the University of Texas at Houston School of Medicine.

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

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

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

---


51 Coalition for the Homeless of Houston/Harris County. Houston/Harris County 2010 Homeless Count & Survey and 2011 Homeless Enumeration Count.

52 The Primary Care Coalition, Texas Academy Family Physicians. The Primary Solution: Mending Texas’ Fractured Health Care System, 2008.

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

Key Challenges

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

- **Inadequate number of primary and specialty care providers.** As discussed throughout this background overview, the region faces a significant shortage of primary and specialty care providers. Patients are unable to obtain to locate a provider willing to serve them, face extended waits for appointments, or are unable to locate a provider with extended hours in order to accommodate work schedules. Addressing this problem requires a long-term solution that includes development of the educational infrastructure as well as programs for attracting and retaining qualified providers.

- **High prevalence of chronic disease, including diabetes, heart disease, asthma, cardiovascular disease and cancer.** The region has high rates of chronic disease, which account for a significant portion of health care spending, are a leading cause of disabilities, and are factors in a majority of deaths. Many of these problems may be alleviated through a coordinated care system that includes improved access to care, patient education, and care management to ensure patients receive the right care at the right time in the right setting.

- **Diverse patient population speaking multiple languages, and with varying cultural backgrounds.** Improving the health care services for a diverse population requires a variety of approaches that are uniquely suited for each population. Without effective patient education and communication programs that address language and cultural barriers, patients will not receive the services they need for the best possible health outcomes and may delay seeking appropriate and preventive care.

- **High number of uninsured patients.** With more than one million uninsured patients, the region struggles to keep up with the demand for services. Patients do not receive basic health

54 Houston Hospitals Emergency Department Use Study.
care services, delay treatment, and often seek primary care services through the emergency rooms, resulting in hundreds of millions of dollars in unnecessary spending.

- **High prevalence of behavioral health conditions and lack of an integrated care solution.** The region lacks both the providers and facilities to adequately meet the demand for behavioral health care, and is often unable to provide an integrated approach that meets both the physical and mental health care needs of the patient. Many individuals may receive either physical treatment or behavioral health care, but not both, or they receive no care at all. The current system is fragmented and difficult to navigate, and challenging for both patients and providers. These problems can be addressed by creating a health service system that is fully coordinated and integrated with behavioral health and primary health care, as well as services provided through school programs, criminal justice systems, and social service providers.

- **Fragmentation of patient services throughout a large, uncoordinated health care system.** Regardless of insurance status, many patients receive fragmented health care that is both inefficient and ineffective. Patients may receive duplicative and unnecessary services, which could be avoided through a regional integrated care system that maximizes the use of electronic health records and health information exchange. While implementation of coordinated care systems involves planning, training and communication strategies that maximize the use of technology and is both challenging and costly, the long-term benefits will be significant in terms of reductions in unnecessary services and costs, and improved patient care and outcomes.

- **Limited access to public transportation and emergency medical services.** Many patients live in areas that provide little or no options for public transportation to obtain medical care, and have very limited options for emergency transportation. Services vary greatly throughout the region, and are especially limited for those living in rural communities that have limited resources and large territories to cover. The absence of these services results in patients delaying necessary care until it becomes a critical health care condition, and relying on emergency transportation for services could have been provided in a primary care setting, or avoided entirely.

- **An aging population and increased need for high-cost services, including behavioral health care.** Although this problem is certainly not unique to Region 3, the large number of individuals that will require increased services (many of whom are already in poor health) poses significant problems. Dealing with these problems will require a coordinated delivery system approach that takes into account the unique physical and behavioral health needs and limitations of the elderly population and a community-wide effort to develop cost effective, long term solutions. Increasing the number of specialty providers, and providing additional training for primary care providers treating older patients are critical challenges that must be met to ensure these patients receive appropriate care and services to ensure the best healthcare outcome possible.

- **Inadequate IT infrastructure necessary for improved care coordination.** Though the region has made progress on the implementation of EHR, extensive expansion and implementation is necessary to meet the future needs of this community. Improvements in health care delivery as well as the monitoring and tracking of progress and outcomes are dependent on an effective program through which providers can track and share patient information and services.
### Summary of Community Needs

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

Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs

Inadequate transportation options for individuals in rural areas and for indigent/low income populations

Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities

Lack of patient navigation, patient and family education and information programs.

Lack of care coordination and unnecessary duplication of services due to insufficient implementation and use of electronic health records

Graduate medical education (residency training) in health care systems, team-based practice, quality improvement, and cost control

<table>
<thead>
<tr>
<th>Community Need Assessment Reports and Resources:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Stakeholder input from RHP 3Working Group Members throughout the Region (including providers, consumers, hospital and clinic administrators, government officials, researchers, and advocacy groups)</td>
</tr>
</tbody>
</table>


25. City of Houston Department of Health and Human Services. HIV/AIDS Awareness for Southwest Region of the City of Houston.


27. Mental Health Policy Analysis Collaborative. *Public Funding For Mental Health Services in Houston – A Financial Map.* University of Texas Health Sciences Center at Houston, December 2009.


29. Mental Health Policy Analysis Collaborative. *The Impact of Mental Illness In Returning Operation Enduring Freedom and Operation Iraqi Freedom Veterans in Houston.* University of Texas Health Sciences Center at Houston, October 2010.


34. Houston, Texas Institute for Health Policy. Health of Houston Survey 2010 – A First Look. The University of Texas School of Public Health.


36. Texas Medical Board, Physician Demographics by County and Specialty, January 2012.


41. Texas Department of State Health Services - Vital Statistics. Onset of Prenatal Care Within the First Trimester, 2008.


Section IV. Stakeholder Engagement
Section IV. Stakeholder Engagement

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

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

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

A. RHP Participants Engagement

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

All of these entities, as well as other stakeholders, were invited to participate in the initial kick-off meeting held February 8, 2012. Among the well-attended meeting were hospital representatives from all facilities that were eligible for Medicaid Uncompensated Care (UC) payments. The meeting included an overview of the waiver activities and requirements, and a summary of the tentative timeline. Speakers included Texas State Representative Garnet Coleman, a local Member of the Texas House of Representatives who was instrumental in developing the legislation that authorized the waiver activities.
In March, key stakeholders were invited to attend the first meeting of the Regional Advisory Committee (RAC). The RAC was created to serve as an oversight entity that provides leadership and guidance for the Region. The RAC includes more than 40 members, including representatives of the hospital and non-hospital performing providers. All meetings are open to the public, but are primarily attended by RAC members.

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

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

B. Public Engagement

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

Information on the website was widely distributed through the hospital district’s communication channels. Other partners, including Performing Providers, were enlisted to also distribute DSRIP planning information and inform individuals of the Region 3 website link. Throughout the planning activities, the Region used the website to post updates from the Health and Human Services Commission; announce meeting dates and locations; provide draft planning documents and project initiatives; and invite comments and feedback from stakeholders. More than 675 people enrolled to receive regular updates through the email distribution list, and that number continues to grow as new people become engaged in this ongoing process. It is through this
process that the Anchor requested public comment on Pass 1 projects – in November – and the full initial draft RHP Plan – in December. An announcement was not only posted on the website, but the email distribution function of the website was used to inform all that the public comment period was open. This website distribution list includes Performing Providers, RAC members, IGT entities, and other relevant stakeholders. Additionally, we requested that OneVoice Texas use their distribution list to announce both public comment periods. OneVoice, though primarily an advocacy group for human services non-profits, has a wide and varied distribution list.

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

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

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

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

<table>
<thead>
<tr>
<th>Month</th>
<th>Meetings Details</th>
</tr>
</thead>
</table>
| March | • 9 Stakeholder Meetings over a 3 day period  
       | • Regional Advisory Committee |
| April | • 9 Stakeholder Meetings over a 3 day period  
       | • Regional Advisory Committee  
       | • Commissioner’s Court presentations  
       | • County Judge and Commissioners meeting |
| May  | • 9 Stakeholder Meetings over a 3 day period |
• Regional Advisory Committee
• Behavioral Health Collaborative
• 3 County Judge and Commissioners meetings
• 2 Fort Bend County Workgroup meetings
• 2 Chambers County Workgroup meetings
• Calhoun County Workgroup meeting
• Matagorda County Workgroup meeting

June:
• 2 Calhoun County meetings
• 2 Chamber County meetings
• 1 Fort Bend County meeting
• 2 Matagorda County meetings
• 1 Waller County workgroup meeting
• 1 Waller County Commissioner’s Court meeting
• 1 Wharton County meeting

July:
• 9 Stakeholder Meetings over a 2 day period
• Regional Advisory Committee
• 2 IGT Performing Providers Collaboration meetings
• Austin County Workgroup meeting
• 2 Colorado County meetings
• 2 Fort Bend County meetings
• 2 Matagorda County meetings
• 2 Wharton County meetings

August:
• Behavioral Health Collaboration meeting
• 1 Chambers County meeting
• 2 Pre and Post Summit Reviews
• 3 IGT Collaboration meetings

September:
• Regional Planning Summit
• 3 IGT Collaboration meetings
• Public Meeting to Present Plan

October:
• 3 IGT Collaborations
• Regional Advisory Committee meeting

November:
• Public Comment Period for Pass 1 Projects – November 9 – 16, 2012
• Public Hearing # 2 – November 20, 2012

December
• Public Comment Period for Pass 1 Projects – December 24 – 31, 2012

Organizations and individuals that participated during the planning and development of our Plan included:
• Consumers
• Patient advocacy representatives
• Public and private hospitals
• Academic Health Centers
• Primary care providers, behavioral health providers, and specialty care providers representing an extensive list of health care practice areas
• Local medical and hospital societies
• Ancillary providers
• Local government officials
• Community planners and administrators
• FQHC administrators and service providers
• Community care clinics
• MHMR Community Centers
• Safety net providers;
• Representatives of religious organizations

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

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

A. RHP Plan Development

The development of the Region 3 RHP plan was a collaborative process inclusive of all nine counties and aspects of provider types to include public, private, political, advocacy, physician practices, etc.

The plan development began with the Anchor, the Harris Health System, designating a waiver team to focus solely on the large task at hand. Individuals of this team were tasked with becoming waiver experts, working with each county & providers as individuals, as well as working hand and hand with HHSC to ensure proper development of the plan.

The Anchor team dedicated countless hours to individual counties, providers, and political leaders to begin with waiver education to allow full engagement of the new system. Distinct workgroup meetings were held in all nine counties to make certain that unique aspects of each community need was addressed in the planning phase of the plan development. Each community had at least 4 onsite meetings of community leaders in order to outline the vast needs of the patient base.

While performing the stakeholder meetings, a community needs assessment process began where the Anchor team requested all previous community needs assessments completed be submitted for review & merging into one regional document. Due to the complexity of the existing healthcare infrastructure of our region, the call for community needs assessments resulted in obtaining over five hundred documents for review and use. Each county was made aware of the community needs assessments and utilized them as a tool in developing initiatives.

As the State process of funding allocations was split into three passes (1, 2, & 3), the regional approach was to identify all needs and allow the three pass process to serve as the funding model for ideas that resulted in the development phase. All performing providers identified an excess of projects for funding & worked directly with the Anchor to identify those projects that would be funded by pass.

IGT entity meetings were established early in the development phase to educate IGT partners on the process, provide State updates, and to review proposed projects for potential funding. Numerous meetings were hosted to allow dialogue between IGT entities and non-IGT entities pertaining to the proposed initiatives. Once the IGT entity identified interest for particular projects negotiations would continue between both parties to ensure compliance with State and Federal expectations.

A Regional Advisory Council was created consisting of representatives from all nine counties and served as a primary point of communication, advocacy group, and advisory council for all projects proposed during the plan development. The initial round of development phase resulted
in over 500 projects that were reviewed & prioritized by the RAC and each community to identify the top initiatives for the region. This prioritized list served as a reference tool as funding was identified by IGT entities.

Passes 1, 2, and 3 had similar processes and included the final review and identification of funding from the primary list of prioritized projects that was created from the initial key stakeholder meetings. Pass 1, and 2 had specific State expectations of funding allocation whereas Pass 3 was a region specific allocation method developed by the Anchor and region stakeholders. The Pass 3 allocation process included a call for all final projects and the region was able to fund all projects with the remaining dollars. Majority of the final projects were included in the original prioritized project list.

Allocations were communicated to all performing providers and IGT entities prior to the finalization of passes to ensure the cost effectiveness of the initiative. It was designated the IGT entities and/or performing providers responsibility to ensure accurate agreements were in place as initiatives were submitted for the final RHP plan.

Once all projects were received, the Anchor worked with both the IGT entity and/or the performing providers to review and edit initiatives and to ensure adequate funding was identified.

B. Project Valuation

IGT entities and/or performing providers were tasked with creating a valuation method specific to the uniqueness of each project, patients served, and organization. Region 3 developed a regional valuation approach as a suggested model as a guide. The region approach combined an allocation model, with a valuation model, and a prioritization model.

- Prioritization Model – Identified the top priorities of the performing provider based on an impact of high, medium, and low.
- Valuation Model – Assigned a weighted value of the patient impact and cost savings associated with the plan which were specific to the uniqueness of each project. This included such items as number of lives served, baseline improvement, healthcare savings cost, lifetime savings cost, community benefit, etc.
- Allocation Model – Utilized Pass 1, 2, or 3 allocation of funds with assigned weight of importance from the valuation & prioritization models.

As this framework was not mandatory, it was utilized as a resource by performing providers and IGT entities to develop the overall valuation process specific to their organization. An example can be found in the Region 3 RHP Plan Addendum section at the end of this document.
Category I
Baylor College of Medicine

Pass 1
Project Option 1.1.1- Establish more primary care clinics: New Baylor Teen Health Clinic at the Tejano Center for Community Concerns

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

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

Category 1 Expected Benefits: The clinic will provide access to age-appropriate, comprehensive primary care services for 4,000 patients by DY5.
Category 3 Expected Benefits:
- Reduce STI rates by 5% compared to baseline by DY5.
- Reduce teen pregnancy rates by 2% compared to baseline by DY5.
- Increase HPV vaccinations by 10% compared to baseline by DY5.

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

The Baylor Teen Health Clinic (BTHC) at seven sites in inner city Houston offers accessible, age-appropriate, comprehensive primary care services to adolescents and young adults living in inner-city Houston, where the economic and health disparities are the greatest. Its services include family planning, screening and treatment for STI and HIV, mental health screening, immunization administration, health risk reduction education, prenatal care, sports

---

physicals, wellness exams, nutrition services, counseling and case management. In addition to providing primary care services, the BTHC works with community partners to connect patients to medical specialists as well as dental, mental health and adoption services. The clinic sites currently serve the Greater Third Ward, Greater Fifth Ward, Kashmere Gardens and Acres Home neighborhoods. In 2011, the BTHC had a total of 9,895 unduplicated client visits at the seven sites. During 2011, there were 2,165 chlamydia cases, 671 gonorrhea cases, 22 syphilis cases and 22 HIV cases. A total of 876 teens between the ages 13-22 tested positive for a pregnancy.

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

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

**5-Year Expected Outcome for Provider and Patients:**
Access to primary care will be increased for 1,500 unique patients by DY 5, with at least 9,000 cumulative patient visits anticipated in the first three years. STI rates will be reduced by 5% compared to the patient population’s baseline through counseling and treatment. Teen birth rates will be decreased by 2% compared to the baseline.

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

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

The clinic at the TCCC is proximal to several medically underserved areas in Houston and will provide access to care for the predominantly Hispanic and Latino population. The

---

metrics selected reflect salient health needs of the adolescent and young adult population, including access to education, counseling and care for STIs and teen pregnancy. Reproductive and sexual health is one of the seven priorities identified in the National Prevention Strategy published by the National Prevention Counsel and the Office of the Surgeon General\(^7\). The BTHC provides services that address each of the four specific recommendations put forth in the strategy: access to preconception and prenatal care; reproductive and supportive services for sexually active teens, pregnant and parenting women; sexual health education, particularly for adolescents; and early detection and treatment of STIs.

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

**Milestones & (Metrics):**
Process Milestones and Metrics: P-2 (P-2.1); P-5 (P-5.1)
Improvement Milestones and Metrics: I-12 (I-12.1); I-X (I-X.1, I-X.2, I-X.3)

The BTHC proposes increases in STI counseling, STI treatment and family planning services as improvement measures for the target population, which lacks access to these and is at particular risk. Nearly 50% of newly diagnosed STIs occur among young adults aged 15-24 years\(^8\). According to the CDC, 40% of sexually active teens did not use a condom the last time they had sex\(^9\). The counseling services at the BTHC focus on reduction of risk behaviors. Although not all patients who are counseled elect to be screened, counseling will be offered to all patients as appropriate, and patients will be informed that screening services are available. Success will be measured through the proposed Category 3 measures below.

Increased access to family planning and contraception services is another proposed improvement measure. High rates of teen birth in the county (63 per 1,000 females aged 15 to 19) and high rates of repeat teen births (23%)\(^10\) make preventing teen pregnancy a cost effective and healthy strategy.

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

**Unique community needs identification number:**
This project addresses the following community needs according to the community needs assessment:

---


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

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
This project significantly enhances the existing delivery system as the expansion to the TCCC will improve primary care access for adolescents and young adults in an area that is medically underserved.

Related Category 3 Outcome Measures:
OD-12 Primary Care and Primary Prevention
• IT-12.6 Other Outcome Improvement Target: Reduction of STI Rate among Adolescents and Young Adults
• IT-12.6 Other Outcome Improvement Target: Reduction of Pregnancy Rate among Adolescents and Young Adults
• IT-12.6 Other Outcome Improvement Target: Increase in HPV Vaccinations among Adolescents and Young Adults

Reasons/Rationale:
Because the BTHC focuses on prevention, the proposed Category 3 milestones and metrics are reduced STI and teen pregnancy rates. Neither the chronic illness milestones nor the primary prevention milestones identified on the Category 3 protocol address the salient health issues faced by adolescents and young adults. Because STIs disproportionately affect this population, it is a more appropriate metric that clearly measures the success of the STI counseling proposed in the Category 1 improvement measures.

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

The importance of immunizations for individual and community health is well documented. The BTHC offers comprehensive primary care services, particularly catch-up immunizations as well as the recommended immunizations for adolescents and young adults. Although the BTHC provides catch-up immunizations for common infectious diseases for patients who need them, HPV was selected because it is usually given in this age group and provides protection against the most common STI among youth. Measuring the number of vaccine administrations will demonstrate the increased impact to individuals and the health of the community overall.

Relationship to Other Projects:

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

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

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

**Project Valuation:**
The value of this project was determined by an econometrics assessment of access to primary care; STI counseling, screening and treatment; and teen pregnancy prevention. The value assigned to primary care is based on cost avoidance of emergency room visits. The difference between the cost of an emergency room visit and the cost of a primary care visit for primary-care-treatable conditions per visit was calculated for the age groups in question\(^\text{14}\). Historical data were reviewed to determine the percentage of preventive and acute care visits. Rather than assume that all acute care visits could result in an emergency room visit, the project value conservatively estimates that a fraction of acute care visits results in an avoided emergency room visit.

Researchers at the CDC have evaluated the cost effectiveness of STI treatment\(^\text{15}\) and developed formulae to assess the direct and indirect cost savings of education, screening and treatment. The formula developed for HIV costs averted by HIV counseling and testing was used to calculate the estimated bundle amount for STI counseling, as HIV counseling is included in all STI education, and screening is available to all patients. The estimated bundle amount for STI treatment was based on the pro rata sequelae costs averted for the treatment of gonorrhea, which is a more conservative estimate than that for treatment of chlamydia or syphilis. Historical data were reviewed to determine the percentage of men vs. women treated. The value for decreases in

\(^{14}\) School of Public Health, *Houston Hospitals Emergency Department Use Study: January 1, 2010 through December 31, 2010*, Houston, Texas: University of Texas Health Science Center at Houston, 2012.

STI rates is based on treatment and pro rata sequelae costs averted because of reductions in the infections in the population, assuming the reductions occur in a patient population of 1,000 patients.

The National Campaign (to Prevent Teen and Unplanned Pregnancy) determined that the cost to Texas taxpayers for teen births in the state between 1991 and 2004 was $15.1 billion\textsuperscript{16}. This cost includes medical expenses, welfare services and productivity loss. The costs averted were broken further into episodic costs that include the cost of delivery and healthcare for mother and child the first year after birth. The remainder was prorated for the life of the Waiver. The expected success of family planning was based on the average teen birth rate for Harris County and the weighted average effectiveness for different types of contraception\textsuperscript{17} based on the historical administration rates. Teen pregnancy rates in the neighborhoods currently serviced by the Teen Clinic are higher than the Harris County average. By reducing the pregnancy rate, we will achieve additional savings in healthcare costs and taxpayer burden that are not duplicated in the estimated bundle for the rendering of contraception management services.

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

\textsuperscript{17} CDC, Reproductive Health, Contraception. \url{http://www.cdc.gov/reproductivehealth/unintendedpregnancy/contraception.htm} Accessed October 4, 2012.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Reduction of STI Rate among Adolescents and Young Adults</th>
<th>Reduction of Pregnancy Rate among Adolescents and Young Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1</td>
<td>N/A</td>
<td>New Baylor Teen Health Clinic at the Tejano Center for Community Concerns</td>
<td>082006001</td>
</tr>
</tbody>
</table>

**Baylor College of Medicine**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>(10/1/2012 – 9/30/2013)</th>
<th>Year 3</th>
<th>(10/1/2013 – 9/30/2014)</th>
<th>Year 4</th>
<th>(10/1/2014 – 9/30/2015)</th>
<th>Year 5</th>
<th>(10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong></td>
<td>[P-2]: Implement a community-based clinic at the TCCC.</td>
<td><strong>Milestone 3</strong></td>
<td>[I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td><strong>Milestone 7</strong></td>
<td>[I-12]: Increase primary care clinic volume.</td>
<td><strong>Milestone 11</strong></td>
<td>[I-12]: Increase primary care clinic volume.</td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>[P-2.1]: Open one additional clinic at the TCCC.</td>
<td><strong>Metric 1</strong></td>
<td>[I-12.1]: Increase number of visits.</td>
<td><strong>Metric 1</strong></td>
<td>[I-12.1]: Increase number of visits by 50% over baseline.</td>
<td><strong>Metric 1</strong></td>
<td>[I-12.1]: Increase number of visits by 100% over baseline.</td>
</tr>
<tr>
<td><strong>Goal</strong>:</td>
<td>Documentation of expansion plan.</td>
<td><strong>Baseline</strong>:</td>
<td>2,000 patient visits.</td>
<td><strong>Goal</strong>:</td>
<td>3,000 patient visits.</td>
<td><strong>Goal</strong>:</td>
<td>4,000 patient visits.</td>
</tr>
<tr>
<td><strong>Data Source</strong>:</td>
<td>New primary care schedule.</td>
<td><strong>Data Source</strong>:</td>
<td>Patient registry / scheduling system.</td>
<td><strong>Data Source</strong>:</td>
<td>Patient registry / scheduling system.</td>
<td><strong>Data Source</strong>:</td>
<td>Patient registry / scheduling system.</td>
</tr>
<tr>
<td><strong>Milestone 1 Estimated Incentive Payment</strong>:</td>
<td>$ 276,925</td>
<td><strong>Milestone 3 Estimated Incentive Payment</strong>:</td>
<td>$ 143,000</td>
<td><strong>Milestone 7 Estimated Incentive Payment</strong>:</td>
<td>$ 146,500</td>
<td><strong>Milestone 11 Estimated Incentive Payment</strong>:</td>
<td>$ 148,250</td>
</tr>
<tr>
<td><strong>Milestone 2</strong></td>
<td>[P-5]: Hire one mid-level provider for the TCCC.</td>
<td><strong>Milestone 4</strong></td>
<td>[I-X]: Provide STI counseling and/or screening to prevent STI transmission.</td>
<td><strong>Milestone 8</strong></td>
<td>[I-X]: Increase STI counseling and/or screening.</td>
<td><strong>Milestone 12</strong></td>
<td>[I-X]: Increase STI counseling and/or screening.</td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>[P-5.1]: Documentation of hiring.</td>
<td><strong>Metric 1</strong></td>
<td>[I-X.1]: Implement counseling service.</td>
<td><strong>Metric 1</strong></td>
<td>[I-X.1]: Increase number of visits by 50% over baseline.</td>
<td><strong>Metric 1</strong></td>
<td>[I-X.1]: Increase number of visits by 100% over baseline.</td>
</tr>
<tr>
<td><strong>Goal</strong>:</td>
<td>Hire one additional mid-level provider.</td>
<td><strong>Goal</strong>:</td>
<td>1,000 visits that include STI counseling and/or screening.</td>
<td><strong>Goal</strong>:</td>
<td>1,500 visits that include STI counseling and/or screening.</td>
<td><strong>Goal</strong>:</td>
<td>2,000 visits that include STI counseling and/or screening.</td>
</tr>
<tr>
<td><strong>Data Source</strong>:</td>
<td>Documentation from Human Resources.</td>
<td><strong>Data Source</strong>:</td>
<td>Patient registry / medical record.</td>
<td><strong>Data Source</strong>:</td>
<td>Patient registry / medical record.</td>
<td><strong>Data Source</strong>:</td>
<td>Patient registry / medical record.</td>
</tr>
<tr>
<td><strong>Milestone 2 Estimated Incentive Payment</strong>:</td>
<td>$ 276,925</td>
<td><strong>Milestone 4 Estimated Incentive Payment</strong>:</td>
<td>$ 143,000</td>
<td><strong>Milestone 8 Estimated Incentive Payment</strong>:</td>
<td>$ 146,500</td>
<td><strong>Milestone 12 Estimated Incentive Payment</strong>:</td>
<td>$ 148,250</td>
</tr>
<tr>
<td><strong>Milestone 5</strong></td>
<td>[I-X]: Treat patients for STIs to reduce transmission and prevent sequelae.</td>
<td><strong>Milestone 9</strong></td>
<td>[I-X]: Increase STI treatments.</td>
<td><strong>Milestone 13</strong></td>
<td>[I-X]: Increase STI treatments.</td>
<td><strong>Milestone 1</strong></td>
<td>[I-X.2]: Increase STI treatment services by 50% over baseline.</td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>[I-X.2]: Increase STI treatment services by 100% over baseline.</td>
<td><strong>Metric 1</strong></td>
<td>[I-X.2]: Increase STI treatment services by 50% over baseline.</td>
<td><strong>Metric 1</strong></td>
<td>[I-X.2]: Increase STI treatment services by 100% over baseline.</td>
<td><strong>Metric 1</strong></td>
<td>[I-X.2]: Increase STI treatment services by 100% over baseline.</td>
</tr>
</tbody>
</table>
### Metric 1 [I-X.2]: Implement treatment services.
- Baseline: 800 visits for STI treatment.
- Data Source: Patient registry / medical record.

Milestone 5 Estimated Incentive Payment: $143,000

### Milestone 6 [I-X]: Provide birth control services to prevent unplanned teen pregnancy.

### Metric 1 [I-X.3]: Implement contraception services.
- Baseline: 500 patients who accept contraception.
- Data Source: Patient registry / medical record.

Milestone 6 Estimated Incentive Payment: $143,000

### Goal: 1,200 visits for STI treatment.
- Data Source: Patient registry / medical record.

Milestone 9 Estimated Incentive Payment: $146,500

### Milestone 10 [I-X]: Increase birth control services.

### Metric 1 [I-X.3]: Increase contraception services by 50% over baseline.
- Goal: 750 patients who accept contraception.
- Data Source: Patient registry / medical record.

Milestone 10 Estimated Incentive Payment: $146,500

### Goal: 1,600 visits for STI treatment.
- Data Source: Patient registry / medical record.

Milestone 13 Estimated Incentive Payment: $148,250

### Milestone 14 [I-X]: Increase birth control services.

### Metric 1 [I-X.3]: Increase contraception services by 100% over baseline.
- Goal: 1,000 patients who accept contraception.
- Data Source: Patient registry / medical record.

Milestone 14 Estimated Incentive Payment: $148,250

---

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (*add milestone bundle amounts over Years 2-5): $2,334,000
Bayshore Medical Center
Pass 1
**Project Option:** 1.1.2 Expand Primary Care Capacity: Expand Obstetrical and Gynecological Care Capacity in East Houston

**Performing Provider:** HCA Bayshore Medical Center/020817501

**Unique Project ID:** 020817501.1.1

- **Provider:** Bayshore Medical Center is a 476-bed facility with its main campus situated in Pasadena, Texas, with an additional campus called East Houston Regional Medical Center located in Houston, Texas. The facility is located in the Houston-Sugarland-Baytown MSA, which serves a population of approximately 6,000,000 people.

- **Intervention(s):** HCA intends to expand OB/GYN care capacity in the existing community clinics by recruiting two (2) new OB/GYNs to the area and by hiring additional support staff. HCA also intends to expand the service hours and days in existing clinics. Finally, HCA will relocate a Pasadena clinic in order to allow for better care coordination and access.

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

- **Target population:** The target population of this project is women of reproductive age seeking OB/GYN services through HCA’s OB clinics in East Houston. The three clinics currently provide over 3000 patient encounters. Of these patients, 93-100% are Medicaid-eligible or uninsured. The project is intended to improve access for the clinics’ existing patients and to allow the clinics to treat a greater volume of Medicaid and uninsured patients in the future.

- **Category 1 or 2 expected patient benefits:** HCA expects that, by recruiting additional OB/GYNs to the East Houston community to maintain and expand obstetrical and gynecological care access for the East Houston patient population, patient satisfaction and health outcomes will improve.
  - **DY2:** HCA does not expect to see any additional patient benefit in DY2, as it will be recruiting and retaining two additional OB/GYNs.
  - **DY3:** HCA expects that there will be an increase of 1255 patient visits, for a total of 4,300 visits.
  - **DY4:** 1685 patient visits, for a total of 4,730 visits (an increase of 10% over DY2), and
  - **DY5:** 2115 patient visits, for a total of 5,160 (an increase of 20% over DY2). HCA will also expand its hours at the main clinic to include one additional weekday per week and one weekend per month. Finally, in DY4, HCA will relocate its Pasadena clinic into a larger site that is more convenient to access via public transportation.
• **Category 3 outcomes:** IT 8.2 – Bayshore intends to reduce the number of low-weight births to its clinic clients by reducing the number of unhealthy pregnancies and early deliveries through regular access to OB/GYN care. Those reductions should increase the infants’ short- and long-term health outcomes, and reduces the cost of providing care to the mothers and infants. The percentage reduction will be determined in DY3.

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

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

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

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

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

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

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

**Starting Point/Baseline:** As of 2012, HCA has 3 current OB/GYN clinic locations include: Midwives of East Houston – Main Office; Midwives of East Houston – Wayside; and Midwives Care Clinic – Pasadena. These locations see patients on Tuesdays and Wednesdays. The clinics are currently served by a total of nineteen (19) OB/GYNs and midwives. With a total of three clinics, they average 387 patients/month (East Houston: 252 patients/month; and Pasadena: 97 patients/month; Wayside: 38 patients/month). The targeted population is indigent woman of child-bearing age and indigent woman with gynecologic needs.

**Rationale:**
HCA chose this project because Harris County has a higher rate of low-birth weight than the statewide rate, a lower rate of mammography screening than the statewide rate, and a rate of sexually transmitted infections equal to the statewide rate. These specific problems, along with myriad of others particular to women of a reproductive age, can be treated and often prevented when women have regular access to an OB/GYN, thus making it imperative for Harris County to increase the availability of these providers in the community. To compound the issue, Harris County has a higher rate of uninsured residents than the statewide rate (almost 1 in 3 residents), meaning that access to OB/GYNs willing to treat indigent patients is also imperative for the health of women in Harris County.
Project Components:
HCA will meet the core requirements of this project in the following manner:

a. **Expand primary care clinic hours:** HCA will increase the hours at the Main Office by at least one day per week and offer weekend hours at least once per month, enabling working and school-age girls to access OB/GYN primary care.

b. **Expand primary clinic space:** HCA will relocate its Pasadena clinic location into a larger space that is closer to an FQHC and public transportation.

c. **Expand primary care clinic staffing:** HCA will recruit two (2) additional OB/GYNs into its community clinics, and will hire additional staff to support the increased patient load, which will include two (2) new MAs, an Office Coordinator, and a Medicaid Enrollment Coordinator.

Unique Community Needs Identification Numbers:

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

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

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

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

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

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

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

**Project Valuation:** The valuation of each HCA project takes into account the degree to which the project accomplishes the triple aim of the Waiver: community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Specifically, this project valuation incorporates the difficulty of recruiting and retaining OB/GYN providers, and need for increasing the number of local providers in the local clinics to meet patient demand. The valuation also takes into account the emphasis that the Region 3 DSRIP work groups have placed on the expansion of specialist services such as OB/GYN care.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s): OD-6</th>
</tr>
</thead>
</table>

### Year 2
(10/1/2012 – 9/30/2013)

**Milestone 1 [P-5]:** Train/hire additional primary care providers and staff.

**Metric 1[P-5.1]:** Documentation of increased number of providers and staff

Baseline/goal: Currently, HCA experiences about 3,045 patient visits with 19 OB/GYNs. In DY2, HCA will recruit and retain two (2) additional OB/Gyns to serve in HCA’s three local clinic spaces.

Data Source: Documentation of physician’s recruitment and retention

**Milestone 1 Estimated Incentive Payment (maximum amount):** $3,610,752

### Year 3
(10/1/2013 – 9/30/2014)

**Milestone 2 [P-5]:** Train/hire additional primary care providers and staff.

**Metric 1[P-5.1]:** Documentation of increased number of providers and staff

Baseline/Goal: Recruit and retain two (2) Medical Assistants, one (1) Office Coordinator, and one (1) Medicaid Enrollment Coordinator to serve in HCA’s three local clinic spaces.

Data Source: Documentation of support staff recruitment and retention

**Milestone 2 Estimated Incentive Payment:** $1,969,568

### Year 4
(10/1/2014 – 9/30/2015)

**Milestone 4 [P-1]:** Relocate primary care clinic.

**Metric1 [P-1.1]:** Expanded space

Baseline/goal: Bayshore relocate its Pasadena clinic location to a larger space that it identifies as more convenient to public transportation and closer to the local FQHC

Data source: floor plan and location information of new space, and documents evidencing the relocation

**Milestone 4 Estimated Incentive Payment:** $1,975,293

### Year 5
(10/1/2015 – 9/30/2016)

**Milestone 6 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 [I-12.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period.

Goal: HCA will measure the clinic volume of patients during DY4, and demonstrate a 70% improvement over DY2 during DY5.

Data Source: Clinic registry and/or electronic health records

**Milestone 6 Estimated Incentive Payment:** $3,263,529

Estimated patient impact: 5,160 total patient visits.
<table>
<thead>
<tr>
<th>020817501.1.1</th>
<th>1.1.2</th>
<th>1.1.2 A-C</th>
<th><strong>Expand Primary Care Capacity: Expand Obstetrical and Gynecological Care Capacity in East Houston</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCA – Bayshore Medical Center</strong></td>
<td></td>
<td></td>
<td><strong>Percentage of Low birth weight births</strong></td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s): OD-6</strong></td>
<td><strong>IT-8.2</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Day per month. Data Source: Clinic documentation from DY2 and DY3 showing increase in hours</td>
<td></td>
<td>Milestone 5 Estimated Incentive Payment: $1,975,293</td>
<td>Estimated patient impact: 4,730 total patient visits.</td>
</tr>
<tr>
<td>Estimated patient impact: 4,300 total patient visits.</td>
<td>Milestone 3 Estimated Incentive Payment: $1,969,568</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 3 Estimated Incentive Payment: $1,969,568</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone):</strong> $3,610,752</td>
<td><strong>Year 3 Estimated Milestone Bundle Amount:</strong> $3,939,136</td>
<td><strong>Year 4 Estimated Milestone Bundle Amount:</strong> $3,950,587</td>
<td><strong>Year 5 Estimated Milestone Bundle Amount:</strong> $3,263,529</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR Period (add milestone bundle amounts over Years 2-5):** $14,764,004
**Project Option:** 1.7.1 Implement Telemedicine program to provide or expand specialist referral services in an area identified as needed to the region: Behavioral Health Telemedicine Services  
**Performing Provider:** HCA Bayshore Medical Center/020817501  
**Unique Project ID:** 020817501.1.2

- **Provider:** Bayshore Medical Center is a 476-bed facility with its main campus situated in Pasadena, Texas, with an additional campus called East Houston Regional Medical Center located in Houston, Texas. The facility is located in the Houston-Sugarland-Baytown MSA, which serves a population of approximately 6,000,000 people.
- **Intervention(s):** HCA intends to expand its existing telemedicine program to include a 24/7 tele-psychiatry program in its Bayshore Emergency Department (ED), as well as implementing telemedicine capabilities in the EDs at its other local hospitals. Specifically, HCA will identify the necessary technology to establish the program, reach out to behavioral health providers to participate, train the ED staff at each hospital to effectively use the new capabilities, and will implement protocols for obtaining tele-psychiatry consults and referrals to and from Bayshore.
- **Need for the project:** Currently, the time from “Initial Contact to Assessment Completion” at the other HCA hospital EDs includes four hours (on average) for the QMHP to arrive, another two hours to complete the assessment, and additional time to obtain a transfer for treatment (which can take days). As a result, the BH/SA patients often languish in area EDs for days awaiting a transfer. This project is intended to more efficiently use the limited staff resources when dealing with overcrowding in the Bayshore ED to provide consults to its own patients and the patients in its sister EDs in a timelier manner.
- **Target population:** The target population of this project is the residents of the community with behavioral health and substance abuse issues who are likely to seek care in area EDs. HCA’s Houston EDs experience 8000-9500 BH/SA related visits per year, with 2800-3500 requiring in-depth psychiatric assessments for appropriate placement. Of these patients, approximately 57-67% are Medicaid-eligible or uninsured. The average time from decision to transfer for these patients is 4-8 hours. Bayshore’s ED receives 500-650 BH/SA patient requiring in-depth psychiatric assessments per year, which leads to overcrowding when coupled with the fact that many patients are put in a hold pattern for hours, or even days.
- **Category 1 or 2 expected patient benefits:** The 24/7 telemedicine capability system should improve the quality, timeliness, and efficiency of consultations and referrals provided to BH/SA patients at hospitals in the area.
  - In **DY2:** HCA expects that implementation of a telemedicine project in DY2 will have a patient impact of about 2100 assessments.
  - **DY3:** 2310 (a 10% increase from the expected DY2 baseline).
  - **DY4:** 2520 in DY4 (a 20% increase from DY2).
  - **DY5:** 2730 in DY5 (a 30% increase from DY3).

**Category 3 outcomes:** IT 3.8 – Behavioral Health / Substance Abuse 30 day readmission rate. Bayshore will reduce the readmission rate for BH/SA rate by 10% in DY4 over the baseline set in DY3, and by 15% in DY5 over the baseline set in DY3. By increasing access
to these much needed psychiatric services, and providing a more efficient assessment, patients will receive the care they need in a more timely manner. This increased access to services will improve health outcomes by assessing the patient more quickly, which will allow treatment to begin more quickly.

**Project Description:**

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

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

**Goals and Relationship to Regional Goals:**

**Project Goals:**

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

**This project meets the following Region 3 Goals:**

While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following:
Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

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

Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and

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

Challenges:

- Identifying and recruiting willing telepsychiatry providers to furnish consultations and/or referrals to Bayshore and other area hospitals’ ED patients – in order to address this challenge, the hospital will offer competitive compensation to participating providers, and will seek out providers with a calling to treat traditionally underserved patients.

- Identifying and implementing the most effective technology for operating the program – Bayshore will address this challenge by researching the available options and making a reasoned decision, focused on value, cost, and feasibility.

- Training providers to use the new technology – Bayshore will address this challenge by taking time with the ED staff at Bayshore and other area HCA hospitals to orient them to using the technology, and by creating protocols to guide ED providers.

- Coordinating with the other participating hospitals to ensure smooth patient transitions: Patients will need to be transferred from the other area hospitals to Bayshore when the assessment from their consults is that they require inpatient psychiatric care. Coordinating this transition will require protocols and process, which Bayshore will work with the participating providers to develop and implement.

5-year Expected Outcome for Provider and Patients:

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

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

**Rationale:**

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

**Project Components:**

Bayshore will address the core components in the following manner:

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

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

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

**Related Category 3 Outcome Measures:**

OD-3; IT 3.8 – Behavioral Health / Substance Abuse 30 day readmission rate.

Bayshore will reduce the readmission rate for BH/SA rate by 10% in DY4 over the baseline set in DY3, and by 15% in DY5 over the baseline set in DY3. By increasing access to these much needed psychiatric services, and providing a more efficient assessment, patients will receive the care they need in a more timely manner. This increased access to services will improve health outcomes by assessing the patient more quickly, which will allow treatment to begin more quickly.

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

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

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

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

**Project valuation rationale:** Specifically, this project valuation considers the difficulty of implementing tele-psychiatry capabilities and integrating those capabilities into the emergency departments at these hospitals, as well as the expected benefits to behavioral health patients presenting at the emergency departments. The valuation also takes into account the emphasis
that the Region 3 DSRIP work groups have placed on the expansion of specialist services and improved access to behavioral health services.
## Implement Telemedicine Program to Provide or Expand Specialist Referral Services in an Area Identified as Needed to the Region: Behavioral Health Telemedicine Services

**HCA – Bayshore Medical Center**

### Related Category 3

<table>
<thead>
<tr>
<th>Outcome Measure(s): OD-3</th>
<th>020817501.3.2</th>
<th>IT-3.8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health / Substance Abuse 30 day readmission rate.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1** [P-3]: Create or expand a telemedicine program for selected medical specialties, based upon community and regional need.

**Metric 1**[P-3.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents.

**Baseline:** At the inception of the Waiver, HCA did not have any telemedicine locations. In late DY2, HCA opened a telemedicine location at its East Houston facility. Goal: Establish a tele-psychiatry program at Bayshore and other area at least three other HCA hospitals in the community, allowing for more timely consultations and referrals of BH/SA patients by specialist providers, resulting in transfers to and from Bayshore (where appropriate); implementation will include identifying provider partners, implementing the technology, training the staff, and creating protocols and process for transfers and referrals.

**Data Source:** Program materials

**Milestone 1 Estimated Incentive Payment:** $3,909,573

**Milestone 2** [P-11]: Participate in face to face learning at least twice per year with other providers and the RHP to promote collaborative learning around similar projects.

**Metric 1** [I-11.1]: Participate in semi-annual face to face meetings or seminars.

**Baseline/Goal:** Bayshore hopes to share ideas with other providers using telemedicine in order to identify best practices and address key challenges going forward at least 2 times per year.

**Data Source:** Documentation of semiannual meetings, including agendas, slides, and/or notes

**Milestone 2 Estimated Incentive Payment:** $2,132,567

**Milestone 3** [P-X1]: Establish a baseline.

**Metric [P-X.1]:** the number of telemedicine visits for specialty identified as high need.

**Goal:** determine the percentage of ED patients at Bayshore, East Houston, West Houston, and Woman’s Hospital presenting with BH/SA needs who utilize the new tele-psychiatry service.

**Data Source:** ED health records for BH/SA patients treated

**Milestone 4 Estimated Incentive Payment:** $4,277,532

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

**Metric 1**[I-12.1]: Number of telemedicine visits.

**Goal:** Increase the number of ED patients at Bayshore, East Houston, West Houston, and Woman’s Hospital presenting with BH/SA needs utilizing tele-psychiatry by 20% over baseline established in DY2, or about 2,520 assessments.

**Data Source:** ED health records for BH/SA patients treated

**Milestone 4 Estimated Incentive Payment:** $3,533,614

**Milestone 5** [I-12]: Increase the number of telemedicine visits for each specialty identified as high need.

**Metric 1**[I-12.1]: Number of telemedicine visits.

**Goal:** Increase the number of ED patients at Bayshore, East Houston, West Houston, and Woman’s Hospital presenting with BH/SA needs utilizing tele-psychiatry by 30% over baseline established in DY2, or about 2,730 assessments.

**Data Source:** ED health records for BH/SA patients treated

**Milestone 5 Estimated Incentive Payment:** $3,533,614

---

**Regional Healthcare Partnership Plan**

**Region 3**

85
<table>
<thead>
<tr>
<th>020817501.1.2</th>
<th>1.7.1</th>
<th>1.7.1 A-B</th>
<th><strong>IMPLEMENT TELEMEDICINE PROGRAM TO PROVIDE OR EXPAND SPECIALIST REFERRAL SERVICES IN AN AREA IDENTIFIED AS NEEDED TO THE REGION: BEHAVIORAL HEALTH TELEMEDICINE SERVICES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCA – Bayshore Medical Center</strong></td>
<td></td>
<td></td>
<td><strong>020817501</strong></td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s): OD-3</strong></td>
<td><strong>020817501.3.2</strong></td>
<td><strong>IT-3.8</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Behavioral Health / Substance Abuse 30 day readmission rate.</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
<tr>
<td>tele-psychiatry program.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data source: ED health records for BH/SA patients treated at the aforementioned facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated patient impact: 2,310 assessments.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 3 Estimated Incentive Payment: $2,132,567</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: <em>(add incentive payments amounts from each milestone):</em> $3,909,573</td>
<td>Year 3 Estimated Milestone Bundle Amount: $4,265,134</td>
<td>Year 4 Estimated Milestone Bundle Amount: $4,277,532</td>
<td>Year 5 Estimated Milestone Bundle Amount: $3,533,614</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD <em>(add milestone bundle amounts over Years 2-5):</em> $15,985,853</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
City of Houston Department of Health and Human Services

Pass 1
Project Option - Project Option 1.8.9 - Expansion of school-based sealant and/or fluoride varnish programs that provide sealant placement and/or fluoride varnish applications to otherwise un-served school-aged children by enhancing dental workforce capacity.

**Unique Project ID:** 0937740-08.1.1

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

**Project Summary:** Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

**Intervention(s):** This new project will improve dental health in Medicaid/CHIP or indigent populations by: 1) expanding new diagnostic, preventive, restorative, and surgical oral health services for safety net eligible persons, 2) expanding an evidence-based dental sealant program for elementary school children in low income areas 3) initiating new diagnostic, preventive, restorative, and surgical oral health services for eligible perinatal women through three months post-partum.

**Need for the Project:** The performing provider anticipates treating fewer cases of Early Childhood Caries (ECC) among the child patients (<6 years of age) it serves by expanding an existing program that provides screening, oral health education, sealants, and fluoride varnish for at-risk 2nd graders that are on CHIP/uninsured.

**Target Population:** The primary target population will be at risk 2nd graders that are in schools with a high proportion of minority and low income families. The secondary target group will be eligible perinatal women through post-partum.

**Category 1 or 2 expected patient benefits:** Increase by 5% over baseline the number of special population members that access services in past 12 months in DY4 and increase by 10% over baseline the number of special population members that access services in past 12 months.

a) For Oral Health for At Risk Population in DY3 a baseline of 3515 children will receive dental sealants, to increase to 3690 in DY4 and 3875 in DY5.

b) For Dental Safety Net, to decrease number of children with untreated caries, a baseline of 850 will be established in DY3, 807 in DY4 and 767 in DY5.
c) For Perinatal Oral Health, to increase the number of pregnant women who access oral health services, the unduplicated baseline is 300 in DY3, 315 in DY4 and 331 in DY5. For total number of encounters, a baseline of 900 will be established in DY3, 945 in DY4 and 993 in DY5.

Category 3 outcomes: IT-7.1 Dental Sealant: Increase percentage of children age 6-9 with a dental sealant on a permanent first molar tooth by 5% over baseline in DY4 and by 10% over baseline in DY5 IT-7.2 Cavities: Increase percentage of children with untreated dental caries by 2% over baseline in DY4 and by 5% over baseline in DY5.

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

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

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

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

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

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

**Perinatal Oral Health**
The project will also add oral health services for pregnant women to the mix of oral health services offered by HDHHS. By providing perinatal diagnostic, preventive, restorative, and surgical oral health services (during pregnancy and through the third month post-partum), the performing provider will improve the health and quality of life for at-risk Houston area mothers and their children.

By the end of the three months post-partum the project would 1) link the perinatal patients to a dental home, 2) provide anticipatory guidance for perinatal women and their children, 3) promote and support breastfeeding practices with anticipatory guidance, e.g., wiping the baby’s gums after breast or bottle feeding and 4) provide a coordinated effort between the prenatal and oral health provider to promote utilization of dental services during pregnancy.

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

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

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

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

- Close gaps/disparities in access to dental care services

This project meets the following regional goals:

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

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

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

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

**Rationale:**
Oral disease is common in the underserved population. Oral disease can lead to poor nutrition; serious systemic illnesses and conditions such as poor birth outcomes, diabetes, and cardiovascular disease; and a diminished quality of life and life expectancy. Inadequate access to oral health services compounds other health issues. It can result in untreated dental disease that not only affects the mouth, but can also have physical, mental, economic, and social consequences. Fortunately, many of the adverse effects associated with poor oral health can be prevented with quality regular dental care, both at home and professionally. Increasing, expanding, and enhancing oral health services will improve health outcomes. Children who have regular access to a dental provider are more likely to have received preventive dental services such as sealant placement. Children who have regular access to a dental provider are less likely to suffer from untreated dental caries. The Centers for Disease Control and Prevention rate the application of sealants within a school-based setting as one of two strongly recommended evidence-based dental public health prevention methods. There is clearly a return on investment associated with dental sealants when applied within a school sealant program: for every $28 spent on placing one dental sealant and preventing decay, at least $70 will be saved by not filling a one-surface cavity.

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

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

Project Components:
This project has no required core components. Major features of the project include:
   a) Increase services to young elementary school children in low income area schools in partnership with the school district and the individual schools, by providing a sealant placement program off-site.
   b) Partnership with University of Texas Dental School, local dental providers to provide enhanced services to target population.
   c) Connect all patients to dental home.
   d) Implement provision of services to perinatal women, most of whom are on Medicaid, through a combination of education, diagnostic, preventive and surgical services to perinatal women through three months post-partum.

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

Unique community need identification numbers that project addresses:
- CN.4 Inadequate access to dental care
- CN.15 Insufficient access to services for pregnant women, particularly low income women
- CN.22 Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities

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

Related Category 3 Outcome Measures:
OD-7 Oral Health
IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Healthy People 2020; CMS Oral Health Initiative goal
IT-7.2 Cavities: Percentage of children with untreated dental caries (Healthy People 2020)
Reasons /rationale for selecting the outcome measures:
The primary outcome measures chosen for this project are: increase in sealant application and reduction in dental caries in elementary school children aged 6-9 years. Elementary school children of this age are a particularly vulnerable because they lose their “baby” teeth and new teeth emerge. In order to ensure the best possible prognosis for the future optimal dental health, both outcomes will be tracked and evaluated. Perinatal women seen in this program will be tracked in terms of an output measure to show an increase in number of women served and offered diagnosis, treatment and preventive care. Improved dental health during the perinatal and postnatal period has positive implications for the dental health of both the mother and the child.

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

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

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

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a predetermined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.
HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. Oral Health Service Expansion received a composite Prioritization score of 7.65 and a Public Health Impact score of 7.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-X1]: Project Planning</td>
<td><strong>Milestone 4</strong> [P-6]: Implement/expand alternative dental care delivery systems to underserved populations</td>
<td><strong>Milestone 8</strong> [I-14]: Increase number of special population members that access dental services</td>
<td><strong>Milestone 9</strong> [I-14]: Increase number of special population members that access dental services</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-X1.1]: Engage stakeholders, identify resources and potential partnerships, develop relationships, develop implementation plan</td>
<td><strong>Metric 1</strong> [P-6.1]: Implement/expand a mobile dental clinic program with an affiliated fixed-site dental clinic location. Documentation of expansion. Documentation includes descriptions of all services provided as well as program management activities.</td>
<td><strong>Metric 1</strong> [I-14.1]: Increasing the number of children and pregnant women, accessing dental services</td>
<td><strong>Metric 1</strong> [I-14.1]: Increasing the number of children and pregnant women, accessing dental services</td>
</tr>
<tr>
<td>Goal: Produce a comprehensive report documenting all points above</td>
<td>Goal: Document expansion of services to underserved target population. Data Source: Dental records documenting exams, treatment, consultations, and referrals</td>
<td>Goal: Increase by 5% over baseline the number of special population members that access services in past 12 months. (Baseline established in DY 3) Data Source: consent forms, other documentation of dental services</td>
<td>Goal: Increase by 10% over baseline the number of special population members that access services in past 12 months. Data Source: consent forms, other documentation of dental services</td>
</tr>
<tr>
<td>Data Source: Program Documentation</td>
<td><strong>Milestone 4 Estimated Incentive Payment: $ 788,717.94</strong></td>
<td>a) For Oral Health for At Risk Population in DY3 a baseline of 3515 children will receive dental sealants, to increase to 3690 in DY4 and 3875 in DY5.</td>
<td>a) For Oral Health for At Risk Population in DY3 a baseline of 3515 children will receive dental sealants, to increase to 3690 in DY4 and 3875 in DY5.</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-4.1]: Establish additional/expand existing dental care clinics or space</td>
<td><strong>Milestone 5</strong> [P-6]: Implement/expand alternative dental care delivery systems to underserved populations</td>
<td>b) For Dental Safety Net, to decrease number of children with untreated caries, a baseline of 850 will be established in DY3, 807 in DY4 and 767 in DY5.</td>
<td>b) For Dental Safety Net, to decrease number of children with untreated caries, a baseline of 850 will be established in DY3, 807 in DY4 and 767 in DY5.</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-4.1]: Number of additional clinics, expanded space and existing available space. Provide documentation of expansion or efficient use of space. Goal: Increase services to underserved target population Data Source: New dental care schedule or other project documentation regarding</td>
<td><strong>Milestone 4 Estimated Incentive Payment: $ 655,610.86</strong></td>
<td>c) For Perinatal Oral Health, to increase the number of pregnant women who access oral health services, the unduplicated baseline is 300 in DY3, 315 in DY4 and 331 in DY5. For total number of encounters,</td>
<td>c) For Perinatal Oral Health, to increase the number of pregnant women who access oral health services, the unduplicated baseline is 300 in DY3, 315 in DY4 and 331 in DY5. For total number of encounters,</td>
</tr>
</tbody>
</table>

**Regional Healthcare Partnership Plan**

**Project Title:** Oral Health Services for At-Risk Populations

Performing Provider Name: City of Houston Health and Human Services

<table>
<thead>
<tr>
<th>0937740-08.1.1</th>
<th>1.8.9</th>
<th>N/A</th>
<th>PROJECT TITLE: Oral Health Services for At-Risk Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth</td>
<td>Percentage of children with untreated dental caries</td>
<td>TPI - 0937740-08</td>
<td></td>
</tr>
</tbody>
</table>

**Metrics:**

- **Metric 1**: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth.
- **Metric 2**: Number of children who receive dental sealants.
- **Metric 3**: Number of children with untreated dental caries.

**Measures:**

- **Measures - Year 2**:
  - Number of children with dental sealants.
  - Number of children with untreated dental caries.
- **Measures - Year 3**:
  - Increase number of children with dental sealants.
  - Decrease number of children with untreated dental caries.
- **Measures - Year 4**:
  - Increase number of children with dental sealants.
  - Decrease number of children with untreated dental caries.
- **Measures - Year 5**:
  - Increase number of children with dental sealants.
  - Decrease number of children with untreated dental caries.

**Goals:**

- Increase number of children with dental sealants.
- Decrease number of children with untreated dental caries.

**Documentation:**

- Program documentation includes descriptions of all services provided as well as program management activities.
- Consent forms, other documentation of dental services.

**Incentive Payments:**

- **Milestone 4 Estimated Incentive Payment: $ 788,717.94**
- **Milestone 5 Estimated Incentive Payment: $ 655,610.86**

**Baseline:**

- **Baseline (DY 3):**
  - Number of children with dental sealants.
  - Number of children with untreated dental caries.

**Yearly Goals:**

- Year 1 (10/1/2012 – 9/30/2013)
- Year 2 (10/1/2013 – 9/30/2014)
- Year 3 (10/1/2014 – 9/30/2015)
- Year 4 (10/1/2015 – 9/30/2016)
| Milestone 2 Estimated Incentive Payment: $788,717.94 | Goal: Increase access through partnerships with dental providers for target population  
Data Source: MOUs, contracts with sealant partners (UT Dental School)  
Milestone 5 Estimated Incentive Payment: $655,610.86  
**Metric [P-4.2]**: Number of additional school-linked health centers/spaces with dental services (dental screenings and off-site mobile sealant and hygiene program for 2nd graders):  
A) Documentation of establishment of additional school-linked health center/space with description of dental services provided.  
B) Program Management process documentation on parent education and empowerment of families and follow-up of findings from screenings  
Goal: Increase access to dental care for elementary school children  
Data Source: Program  
Documentation of the above.  
Milestone 3 Estimated Incentive Payment: $788,717.94 | a baseline of 900 will be established in DY3, 945 in DY4 and 993 in DY5.  
Milestone 8 Estimated Incentive Payment: $2,791,708.61  
**Milestone 6 [P-6]**: Implement/expand alternative dental care delivery systems to underserved populations.  
**Metric [P-6.4]**: Implement program to increase dental services to improve maternal and early childhood oral health. Documentation of implementation (descriptions of all services provided as well as program management activities)  
Goal: Increase access to dental services for target population  
Data Source: Program documentation and referrals  
Milestone 6 Estimated Incentive Payment: $655,610.86  
**Milestone 7 [P-X]**: Increase number of special population members that access dental services. Establish baseline for measuring number of children and pregnant women, accessing dental services who have seen a dental provider within the past 12 months.  
**Metric 1 [P-X.1]**: Collect data to determine the number of children and pregnant women, accessing dental services who have seen a dental provider within the past 12 months.  
Milestone 9 Estimated Incentive Payment: $2,697,943.99 | a baseline of 900 will be established in DY3, 945 in DY4 and 993 in DY5. |
services that have seen by a dental provider within the past 12 months. Baseline Goal: Establish baseline number of special population members that access services in past 12 months. Data Source: consent forms, other documentation of dental services

Milestone 7 Estimated Incentive Payment: $ 655,610.86

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $2,366,153.83</th>
<th>Year 3 Estimated Milestone Bundle Amount: $2,622,443.44</th>
<th>Year 4 Estimated Milestone Bundle Amount: $2,791,708.61</th>
<th>Year 5 Estimated Milestone Bundle Amount: $2,697,943.99</th>
</tr>
</thead>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $10,478,249.87
Project Option 1.7.7 - Implement remote patient monitoring programs for diagnosis and/or management of care for EMS services.

Unique Project ID: 0937740-08.1.2

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

Project Summary: Provider: The primary performing provider, City of Houston Fire Department Emergency Medical Services (EMS) is the primary EMS authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. The City of Houston is a six-hundred plus square mile area spread out over a 1000 square mile region in Southeast Texas. Each year there are over 200,000 EMS incidents involving over 225,000 patients or potential patients. On average, EMS responds to a citizen every 3 minutes. Each EMS response is made by one of 88 City of Houston EMS vehicles. Thirty seven of these are staffed by two paramedics and provide Advanced Life Support (ALS) capabilities. The primary performing provider serves all Houston residents, providing high quality medical care that is not defined solely in terms of life-saving interventions for critically-ill or injured patients. High quality emergency medical care is defined by the decisions made on each and every patient encounter. These services that benefit all Houston residents, and frequently, support those most in need, such as low income mothers and children, the elderly, and Medicaid and minority populations. The telehealth program population is expected to consist of approximately 30% Medicaid enrollees and approximately 20% indigent population.

Intervention(s): The City of Houston proposes to make use of telecommunications technologies and connectivity to triage patients with non-life threatening, mild or moderate illnesses via telemedicine with an emergency physician at the City of Houston EMS base station. This new program intends to address 3780 new patients/year in DY4 and 3960 new patients in DY5 by telehealth technology by providing access to the Emergency Telehealth and Navigation (ETHAN) program.

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

Target Population: This new program will target callers to 9-1-1 who have been evaluated on site by Houston Fire Department (HFD) - Emergency Medical Technicians (EMT) and/or paramedics, and if appropriate, these callers will be directed to the Emergency Tele Health and Navigation (ETHAN) Program to receive appropriate care at the right setting.

Category 1 or 2 expected patient benefits: Improved access to health care services by 5% over baseline in DY4 and by 10% over baseline in DY5 for residents of communities that did not have such services locally before the program. A baseline of 300 patients per month will be established during DY3 from the time the program is fully implemented. In DY4 the number of patients seen by ETHAN will increase to 315 per month for a total of 3780 for DY4 and to 330 per month for a total of 3960 for DY5.
Category 3 outcomes:  **IT-9.4**: (ED appropriate utilization) - Reduce all ED visits that are non-emergent among 911 callers by 5% over baseline in DY4 and by 10% over baseline in DY5.

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

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

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

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

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

Clients with a non-life threatening mild or moderate illness who are not referred to the emergency room by the base station physician will be referred to the CareHouston Links program for follow-up of the plan recommended by the physician. CareHoustonLinkspersonnel will follow-up with the client within a few hours in order to ensure that the plan is appropriate and achievable. Necessary adjustments to the plan would then be made between the client and
navigator. On the following business day, Care Houston Links counselors will follow-up with the patient to determine if the patient in fact followed the advice provided by the physician and navigator, or failed to follow the advice. In situations where the client followed the advice, the counselor will work with the client and their health care provider to ensure continued compliance with the health care plan. In situations where the client failed to follow the advice, the counselor will determine and record what actually happened and the reasons why. They will also troubleshoot the issues that lead to the failure and work with the client to develop a relationship with an acceptable medical home and health care plan.

ETHAN would initiate care coordination services for at least 3600 patients/year by DY4 and 5 by more accurately assessing the 9-1-1 caller’s needs and utilizing low cost transportation opportunities to provide the patient more appropriate care in a more appropriate setting than the emergency center. In order to be maximally successful, multiple primary care providers, such as FQHC’s, other low cost or publically supported health care clinics, and eventually ACO affiliated physician offices and clinics would need to participate. With adequate provider participation, most non-emergent callers to 9-1-1 can be redirected to the source of health care most appropriate for their level of need. Additional savings would include all direct costs currently incurred to pay for ambulance transportation and emergency department evaluation (potentially unnecessary X-rays, laboratory testing, physician and nursing care costs), as well as the many indirect costs that result from the patients being non-compliant with the overall care plan when they choose to utilize emergency services instead of primary care for primary care problems. The ETHAN program will be implemented city wide in Houston, Texas.

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

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

Goals and Relationship to Regional Goals:
The goal of this program is to reduce emergency room transports by ambulance for non-emergent conditions.

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

This project meets the following regional goals:

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

Challenges:

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

5 Year Expected Outcome for Providers and Patients:

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

Starting Point/Baseline:

Houston Fire Department EMS Division (FY 2012):

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

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

Rationale:

This program provides care coordination, by more accurately assessing the 9-1-1 caller’s needs via telemedicine and utilizing low cost transportation opportunities to provide the patient more appropriate care in a more appropriate setting than the emergency center. The performing provider and its partners expect to see a reduction in ER usage among non-emergent 911 callers.
by using telecommunications technologies and connectivity linked with a patient navigation program (CareHouston Links). The MedStar program, a similar program in the Dallas/Fort Worth area, showed large declines in ED charges and costs due to the Medstar program. The number of calls from repeat callers dropped from 342.3 per month to 143.3 per month among the 186 repeat callers that were enrolled in the program. This saved Medstar over $900,000 in transportation costs and hospital charges fell by $2.8 million. During Fiscal Year 2012, the current CareHouston program, which is similar to the MedStar program and which is a partnership between the HFD and HDHHS to follow-up on frequent 9-1-1 callers, diverted 1,458 clients from using EMS transports to emergency departments for non-emergencies, diverting $2,143,260 in costs for the City of Houston.

There are two major ways this program will be able to demonstrate cost savings to the Health Care System:
1. Diverted ambulance transports
2. Diverted emergency department visits for non-emergencies.

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

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

**Unique Community Need identification numbers that project addresses:**
- CN.1- Inadequate access to primary care 2,3
- CN.8- High rates of inappropriate emergency department utilization 2,3

**How the Project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
Currently the Houston Fire Department uses the Alternate Transportation Program which allows field personnel (EMT’s and paramedics) to connect low acuity patients with a paramedic at the centralized base station via telephone where the paramedic interrogates the patient utilizing a telehealth nurse triage algorithm to determine if alternatives to ambulance transportation to an emergency department is safe. Using City of Houston funds through a contract with the Harris County Healthcare Alliance, this program currently financially supports taxi cab transportation and clinic costs (one time only) for patients to be seen at a Houston area federally qualified healthcare center (FQHC). The program is poorly utilized by field personnel for three reasons:
a) The telehealth nurse triage algorithm is designed for a non-emergency setting application and is extremely conservative resulting in a high frequency of recommendations for emergency department evaluation.

b) The interrogation required is time consuming and inefficient

c) The public is unfamiliar with the concept and is not trusting of a non-physician on a telephone giving them advice.

ETHAN is a new program which will replace the Alternative Transportation program which will utilize an emergency physician via technology to assess and determine a recommended course of health care for patients seen by EMTs and paramedics. This program will result in patient’s receiving advice from an actual physician who is located at the base station, as a service does not currently exist.

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

**Related Category 3 Outcome Measures**

OD- 9 Right Care, Right Setting

IT-9.4 Other Outcome Improvement Target (ED appropriate utilization of non-life threatening, mild or moderately ill 911 callers)

Rate: Non-life threatening, mild or moderately ill 911 callers connected to further medical care/follow-up during the project year

**Reasons/Rationale for selecting the outcome measures:**

We chose the outcome measure of inappropriate ED usage in the “Other Outcome Improvement Target” category. By providing access to Telehealth services, this program aims to reduce inappropriate ER usage of non-life threatening, mild or moderately ill 911 callers by telehealth and care coordination; by more accurately assessing the 911 caller’s needs to provide the patient more appropriate care in a more appropriate setting than the emergency room. In order to be maximally successful, partnerships with multiple primary care providers, such as FQHC’s, other low cost or publically supported health care clinics, and eventually ACO affiliated physician offices and clinics will be needed. With their participation, most non-emergent, non-life threatening, mild or moderately ill 911 callers can be redirected to the most appropriate source of health care.
**Relationship to other projects:** This project is related to CareHouston Links. This project’s focus is on providing appropriate care to non-emergent patients that enter the 911 call system due to a variety of reasons in addition to those callers with non-life threatening, mild or moderately illnesses. By keeping the patients from making an unnecessary ER visit, and providing culturally competent navigation services to redirect patients to an alternate source of care, savings to the health care system per patient will be considerable.

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

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

**Project Valuation:**

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

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

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The ETHAN Program received a composite Prioritization score of 7.15 and a Public Health Impact score of 8.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
| **Milestone 1** [P-X1]: Determine scope, range, current capacity and needed resources for the ETHAN Project.  
Metric 1: Provide report identifying ETHAN Program Planning Materials, Meeting minutes, Sign-in sheets, Draft Clinical Protocols, Staff Qualifications, Staffing Plan  
Goal: Provide reporting identifying information listed above  
Data Source: Completed report documenting planning activities | **Milestone 5** [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need.  
Metric 1 [P-4.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents. Submission of implementation documentation  
Goal: Implement program based on community need  
Data Source: Program materials. | **Milestone 9** [I-18]: Implement interventions to achieve improvements in access to care of patients receiving telemedicine/telehealth services using innovative project option.  
Metric 1 [I-18.3]: Improved access to health care services for residents of community that did not have such services locally before the program.  
Goal: Improve by 5% over baseline, (at 315 patients per month for 3780 patients for DY4) the total number of unique patients from underserved communities over baseline (baseline established in Yr 3 of 300 patients per month starting at implementation of program). Data Source: Registry, EHR, claims or other Performing Provider source | **Milestone 9** [I-18]: Implement interventions to achieve improvements in access to care of patients receiving telemedicine/telehealth services using innovative project option.  
Metric 1 [I-18.3]: Improved access to health care services for residents of community that did not have such services locally before the program.  
Goal: Improve by 10% over baseline (at 330 patients per month for 3960 patients for DY5), the total number of unique patients from underserved communities over baseline  
Data Source: Registry, EHR, claims or other Performing Provider source |
| **Milestone 2** [P-X2]: Establish Baseline  
Metric 1: Document number of non-emergent 911 calls to EMS  
Goal: Determine baseline on which program improvements will be based  
Data Source: HFD Data Electronic Records  
Metric 2: Collect and Document | **Milestone 6** [P-X3]: Update scope, range for the ETHAN Project.  
Metric 1: Updated final clinical protocols, List of Stakeholders  
Metric 2: Documentation of program process data related to implementation.  
Goal: Finalize protocol for program implementation | **Milestone 10**: [I-17]: Improved access to needed services, e.g. community based nursing, case management, patient education, counseling, etc. | **Milestone 11** Estimated Incentive Payment: $1,340,373.02 |
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Metric 1 [P-8.1]:** Documentation of expansion of services utilizing the internet. Submission of plan identifying which services can be made available through internet applications as well as steps to implement these services.
- **Goal:** Utilize internet for enhancing program
- **Data Source:** Program plan
- **Milestone 7 Estimated Incentive Payment:** $651,431.69

**Metric 1 [I-17.1]:** Percentage of patients in the telemedicine/telehealth program that are seeing a specialist or using the services for the first time.
- **Goal:** Improve by 5% over baseline the percentage of patients using services for the first time.
- **Data source:** EMR or other program records
- **Milestone 10 Estimated Incentive Payment:** $1,386,956.48

**Regional Healthcare Partnership Plan**

**Region 3**

**Milestone 12 Estimated Incentive Payment:** $1,340,373.02
<table>
<thead>
<tr>
<th>Metric: Engage stakeholders, identify resources and potential partnerships, and develop intervention plan (including implementation, evaluation, and sustainability). Goal: Establish buy-in from community and partners by sharing needs assessment Data Source: Needs Assessment, Meeting minutes, draft intervention plan of services to be offered Milestone 4 Estimated Incentive Payment: $587,767.72</th>
<th>Metric 1 [P-5.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents. Submission of implementation documentation Goal: Conduct patient monitoring Data Source: Program materials Milestone 8 Estimated Incentive Payment: $651,431.69</th>
<th>Year 2 Estimated Outcome Amount: $2,351,070.86</th>
<th>Year 3 Estimated Outcome Amount: $2,605,726.77</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $10,411,456.63</td>
<td>Year 4 Estimated Outcome Amount: $2,773,912.95</td>
<td>Year 5 Estimated Outcome Amount: $2,680,764.04</td>
<td></td>
</tr>
</tbody>
</table>
City of Houston Department of Health and Human Services
Pass 3
Project Option - 1.8.11 The implementation of dental services for individuals in long-term care facilities, intermediate care facilities, and nursing homes, and for the elderly, and/or those with special needs by enhancing dental workforce capacity through collaborations and partnerships with dental and dental hygiene schools, LHDs, FQHCs, and/or local dental providers

**Unique Project ID:** 0937740-08.1.3

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

**Project Summary:** Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 4 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

**Intervention(s):** This new project will improve oral health by providing diagnostic, preventive, restorative, and surgical oral health services for the elderly to improve the health and quality of life for Houston area at-risk seniors. Training the next public health work force is also a goal of the program. 4th year dental students from the University of Texas School of Dentistry (UTSD), dental hygiene students from UTSD, and dental hygiene students from Houston Community College (HCC) will be trained to provide dental care for the seniors within one of the HDHHS safety net dental clinics.

**Need for the Project:** By 2040, the number of US seniors, over the age of 65, is expected to double to 71 million. By 2030, the number of seniors, over the age of 85, is expected to be 9.6 million. As the US seniors live longer, many will be retaining their teeth and many will experience co-morbidities.). Older persons who live below the poverty line were almost three (3) times as likely to report unmet dental needs as those who live at or above the poverty line (11 and 4 percent, respectively).

**Target Population:** The primary target population will be at risk low income or indigent seniors seen at public clinics and FQHC’s. More than 80% of the target population is usually low income or indigent in these clinic settings.

**Category 1 or 2 expected patient benefits:** [I-14] Increase by 5% over baseline of special population members that access dental services in DY4 and by 10% over baseline in DY5. In
DY3, 60 indigent oral health patients will be served, in DY4, 63 indigent patients will be served and in DY5, 66 oral health patients will be served.

**Category 3 outcomes:** IT-7.8: Increase by 5% over baseline percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider in DY4 and by 10% over baseline in DY 5.

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

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

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

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

In 2013, the HDHHS will provide oral health services at-risk seniors, in conjunction with UTSD and HCC students, in a first time endeavor with HCAAA and neighboring Fort Bend County Area Agency on Aging. The UTSD has already donated dental chairs for this initiative.
Cost savings are realized with prevention. At-risk seniors, having a history of oral health neglect and dry mouth issues, often present with chronic oral health problems, e.g., caries, non-restorable teeth, and lesions, and an inability to chew healthy foods. To assist these seniors from poor oral health to improved oral health can be costly. However, once better oral health is realized and with proper guidance, cost-effective preventive care can ensue. Early detection of oral cancers has shown to be cost effective. At a cost of $84/person/year, significant health benefits and cost savings can be realized. The earlier a cancer is detected, the better the outcome, and the treatment, if needed, is less costly as well. The cost of screening and early detection is approximately 46% less than treatment alone, e.g., $260,351 vs $478,742.

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

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

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

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

- Close gaps/disparities in access to dental care services

This project meets the following regional goals:

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

Challenges:
Some of the challenges the provider anticipates follow:
1) Developing an efficient and effective referral process: For dental procedures beyond the HDHHS’ scope of services, refer to Harris Health System and UTSD for oral surgery, UTSD School of Dentistry for Endodontics and Periodontics.
2. Identifying sustainable funding stream
3. Identifying and hiring trained dentists

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

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

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

Nearly one-third of persons 65 years of age and older have untreated dental caries. Slightly more than one-half of non-institutionalized persons 65 years of age and older in 1997 had a dental visit in the past year. Oral health problems can hinder an elderly person’s ability to be free of pain and discomfort, to maintain a satisfying and nutritious diet, and to enjoy interpersonal relationships and a positive self-image. Overall, oral health problems are more frequently found in an older adult population for whom other health problems are often a priority. [http://www.cdc.gov/nchs/data/ahcd/agingtrends/03oral.pdf](http://www.cdc.gov/nchs/data/ahcd/agingtrends/03oral.pdf).
Project Components:
This project has no required core components. Major features of the project include:

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

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

Unique community need identification numbers that project addresses:
- CN.4 Inadequate access to dental care
- CN.22 Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities

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

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

Reasons /rationale for selecting the outcome measures:
The primary outcome measures chosen for this project are increase in number of elderly patients with chronic diseases who access dental care through the program. Multiple comorbidities may place this target population at an even higher risk for complications if they also suffer from poor oral health. By providing dental care and connecting these patients to a dental home, the performing provider expects to see improved oral health in the patients who access this program.
**Relationship to Other Projects and Plan for Learning Collaborative:**
Project results and lessons learned will be disseminated and shared with other members in the regional learning collaborative in efforts to identify and implement quality improvement strategies. We plan to participate in a region-wide learning collaborative as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region, that have similar projects, will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous quality improvement in our Region’s healthcare system.

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

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

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

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

**References**
**PROJECT TITLE: Oral Health Services for Elderly At-Risk Populations**

Performing Provider Name: Houston Department of Health and Human Services

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measures:</th>
<th>0937740-08.3.15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td><strong>Milestone 1</strong> [P-X1]: Project Planning Metric 1 [P-X1.1]: Engage stakeholders, identify resources and potential partnerships, develop relationships, develop implementation plan Goal: Produce a comprehensive report documenting all points above Data Source: Program Documentation</td>
<td><strong>Milestone 4</strong> [P-6]: Implement/expand alternative dental care delivery systems to underserved populations Metric 1 [P-6.1]: Implement/expand a mobile dental clinic program with an affiliated fixed-site dental clinic location. Documentation of expansion. Documentation includes descriptions of all services provided as well as program management activities. Goal: Document expansion of services to underserved target population. Data Source: Dental records documenting exams, treatment, consultations, and referrals</td>
</tr>
<tr>
<td><strong>Milestone 1</strong> Estimated Incentive Payment: $61,053.43</td>
<td><strong>Milestone 4</strong> Estimated Incentive Payment: $51,982.82</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-4.1]: Establish additional/expand existing dental care clinics or space Metric 1 [P-4.1]: Number of additional clinics, expanded space and existing available space. Provide documentation of expansion or efficient use of space. Goal: Increase services to underserved target population Data Source: New dental care schedule or other project documentation regarding expansion</td>
<td><strong>Milestone 6</strong> [P-6]: Implement/expand alternative dental care delivery systems to underserved populations Metric 1 [P-6.5]: Metric: Implement program to increase dental services to individuals in longterm</td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 8</strong>: Increase the number of patients treated by fourth year dental students and dental residents during special population externships and rotations. I-12.1. Metric: Increase number of patients treated by fourth year dental students during externship training opportunities a. Numerator: Total number of special population patients treated by fourth year dental students during externship opportunities (with appropriate faculty oversight) b. Denominator: Total number of special population patients treated during externship opportunities (by site staff only) Goal: In DY3, 60 indigent oral health patients will be served, in DY4, 63 indigent patients will be served and in DY5, 66 oral health patients will be served. c. Data Source: Billing and treatment records</td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 9</strong> Estimated Incentive Payment: $218,552.08</td>
</tr>
<tr>
<td>0937740-08.1.3</td>
<td>1.8.11</td>
</tr>
<tr>
<td>----------------</td>
<td>--------</td>
</tr>
<tr>
<td>Performing Provider Name: Houston Department of Health and Human Services</td>
<td>TPI - 0937740-08</td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measures:</strong></td>
<td><strong>0937740-08.3.15</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment $61,053.43</td>
<td>Milestone 3 [P-4]: Expand and establish additional clinics or space</td>
</tr>
<tr>
<td>Milestone 1 [P-4.2]: Number of additional school-linked health centers/spaces with dental services (dental screenings and off-site mobile sealant and hygiene program for 2nd graders):  A) Documentation of establishment of additional school-linked health center/space with description of dental services provided.  B) Program Management process documentation on parent education and empowerment of families and follow-up of findings from screenings</td>
<td>Goal: Increase access to dental care for elderly  Data Source: Program Documentation of the above.</td>
</tr>
<tr>
<td>0937740-08.1.3</td>
<td>1.8.11</td>
</tr>
<tr>
<td>----------------</td>
<td>--------</td>
</tr>
<tr>
<td>Performing Provider Name: Houston Department of Health and Human Services</td>
<td>TPI - 0937740-08</td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measures:</strong></td>
<td>0937740-08.3.15</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Milestone 3 Estimated Incentive Payment $61,053.43</td>
<td>“raise the floor” initiatives for improved delivery of services. Data Source: Documentation of semiannual meetings including meeting agendas, meeting notes.</td>
</tr>
<tr>
<td><strong>Milestone 7 [I-14]:</strong> Increase number of special population members that access dental services. Establish baseline of 60 indigent oral health patients that receive services in DY3 for measuring number of elderly target population, accessing dental services who have seen a dental provider within the past 12 months.</td>
<td>Metric 1 [P-X.1]: Collect data to determine the number of elderly target population, accessing dental services that have seen by a dental provider within the past 12 months. Baseline Goal: Establish baseline number of special population members that access services in past 12 months. Data Source: consent forms, other documentation of dental</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>0937740-08.1.3</td>
<td>1.8.11</td>
</tr>
<tr>
<td>----------------</td>
<td>--------</td>
</tr>
<tr>
<td>Performing Provider Name: Houston Department of Health and Human Services</td>
<td>TPI - 0937740-08</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measures:</td>
<td>0937740-08.3.15</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>services</td>
<td></td>
</tr>
<tr>
<td>Milestone 7 Estimated Incentive Payment: $51,982.82</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $183160.31</td>
<td>Year 3 Estimated Milestone Bundle Amount: $207,931.27</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $836,866</td>
<td></td>
</tr>
</tbody>
</table>
Columbus Community Hospital

Pass 1
Project Option 1.7.1 - Implement Telemedicine Program to Provide or Expand Specialist Referral Services in an Area Identified as needed to the region

Unique RHP Project Identification Number: 135033204.1.1.

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

Project Description Summary:

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

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

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

- **Target population:** The target population is our patients that need medication consultations after hours. Approximately 70% of our patients are either Medicaid/Medicare eligible or indigent, so, a significant benefit is expected for the patients as well as for the Medicare/Medicaid programs.

- **Category 1 expected patient benefits:**
  - The project seeks to reduce medication areas by 3% in year 3, additional 3% in year 4 and additional 4% in Year 5.
  - The project seeks to provide 150 telemedicine consults in DY4 and 200 in DY5.

- **Category 3 outcomes:** IT-6.1 Our goal is to reduce the 30-day potentially preventable all-cause current readmission rate of 21.4% by 1% in year 2, an additional 1% in year 3, an additional 2% in year 4, and an additional 2% in year 5.
Project Option 1.7.1 - Implement telemedicine program to provide or expand specialist referral services: Implement Telemedicine Program to Provide or Expand Specialist Referral Services in an Area Identified as needed to the region

**Unique RHP Project Identification Number:** 135033204.1.1.

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

**Project Description:**

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

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

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

**Goals and Relationship to Regional Goals:**

**Project Goals:**

- Provide electronic health care services to increase patient access to health care.
- Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care.
- Provide pharmacy service for weekend hours not currently available for inpatients.

This project meets the following Region 3 goals:

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

**Challenges:**

- Finding and contracting with a Pharmacy consulting company to provide telehealth services needed. This challenge was addressed by requesting current pharmacy providers to expand services offered to include this telemedicine service.
- Incorporating the telemedicine procedure into the workflow and thereby changing the culture for the employees. This will be addressed by additional education for the pharmacy staff and nursing staff.
- Without a Pharmacist on duty, there are a higher number of medication errors in hospitals. The challenges are from medications the patient was on prior to admission, to equivalent medications stocked by the admitting hospital, the administration of these different medications by pharmacy staff and errors upon dismissal.

**5 Year Expected Outcome for Provider and Patients:**

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

**Starting Point/Baseline:**

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

**Rationale:**

Columbus Community Hospital wants to improve patient safety through improving pharmacist oversight of prescriber orders. The use of remote service will increase the percentage of orders that are reviewed prospectively prior to initiation of therapy or decrease the amount of time between initiation of therapy and retrospective pharmacist order review. Remote pharmacists will perform a drug regimen review of all patients (including psychiatric and pediatric patients), that will include review for allergy contraindications; reasonable dose (special scrutiny of pediatric patients), route and directions for use; drug/drug, drug/food, and drug/disease interactions; and therapy duplications. Remote pharmacists will make clinical interventions to address any identified issues and to clarify orders. The pharmacist will intervene to make dosage adjustments for renal, vancomycin, aminoglycoside or other dosage recommendations. Pediatric doses can be assessed and a double check performed by a pharmacist for increased patient safety. More timely review of orders will help prevent near misses from becoming medication administration errors. Adverse drug reactions will be identified and reported. Remote pharmacists can assist with cost containment by assisting with conversion of IV to bioequivalent oral therapy, identification and use of patient's own medication, and recommendations for non-formulary to formulary agents. From the American Society of Healthcare Pharmacists’: Review of medication orders. All medication orders shall be prospectively reviewed by a pharmacist and assessed in relation to pertinent patient and clinical information before the first dose is administered or made available in an automated dispensing device, except in emergent situations in which the treatment of the patient would be significantly compromised by the delay that would result from pharmacist review of the order. There shall be a procedure for retrospective review of these orders. Any questions regarding an order shall be resolved with the prescriber prior to administration, and any action taken as a result of this intervention should be documented in the patient’s medical record. Information concerning changes shall be communicated to the appropriate health professionals caring for the patient.¹

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

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

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

b) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities include but are not limited to identifying project impacts, identifying lessons learned

Opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations

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

- Process Milestones and Metrics: P-4 (P-4.1, P-4.2)
- Improvement Milestones and Metrics: I-12 (I-12.1)

**Unique community needs identification numbers:**
- CN 2. – Insufficient access to specialty care (pharmacist)

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This project represents a new initiative for our hospital. We will implement telemedicine to provide oversight and guidance to our patients for pharmacy services after hours and on weekends and supports our efforts to reduce medication errors.

**Related Category 3 Outcome Measure**
OD 3 Potentially preventable readmissions – 30 day readmission rates

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

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

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

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

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

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

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

Columbus is a rural community with 44.8% of the population over the age of 45. Unplanned readmissions are difficult for the adult and geriatric population and reducing rate of unnecessary admissions. This project has important benefits to the community at large.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measures:</th>
<th>IMPLEMENT TELEMEDICINE PROGRAM TO PROVIDE OR EXPAND SPECIALIST REFERRAL SERVICES IN AN AREA IDENTIFIED AS NEEDED TO THE REGION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>10/10/2012-9/30/2013</td>
<td>Milestone 1 [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need. Metric 1 [P-4.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents. Baseline/Goal: Increase from no pharmacy weekend coverage to 8 hours of total coverage per weekend (4 hours each Saturday and Sunday). Data Source: Schedule of contract pharmacy coverage for Columbus Community Hospital Milestone 1: Estimated Incentive Payment: $61,920.00</td>
</tr>
<tr>
<td>Year 3</td>
<td>10/01/2013-9/30/2014</td>
<td>Milestone 2 [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need. Metric 1 [P-4.1]: Documentation of program materials including submission of implementation documentation with increased hours and improved clinical outcomes. Baseline: Increase from 4 hours each Saturday and Sunday to 8 hours plus all holidays to provide pharmacist overnight via telemedicine. Goal: Reduction of the medication error rate by 3% during the year. Data Source: In house statistics from EHR medication errors. Milestone 2: Estimated Incentive Payment: $134,790.00</td>
</tr>
<tr>
<td>Year 4</td>
<td>10/01/2014-9/30/2015</td>
<td>Milestone 3 [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need. Metric 1 [P-4.2]: Documentation of the quantity of actual telehealth services delivered after implementation with improved clinical outcomes. Goal: Reduction of the medication error rate by 3% during the year. Data Source: In house statistics from EHR medication errors. Milestone 3 Estimated Incentive Payment: $66,970</td>
</tr>
<tr>
<td>Year 5</td>
<td>10/01/2015-09/30/2016</td>
<td>Milestone 5 [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need. Metric 1 [P-4.2]: Documentation of the quantity of actual telehealth services delivered after implementation with improved clinical outcomes. Goal: Reduction of the medication error rate by 4% during the year. Milestone 5 Estimated Incentive Payment: $59,650</td>
</tr>
</tbody>
</table>

Baseline/Goal: 

Metric 1 [I-12.1]: Number of telemedicine consultations Baseline/Goal: Increase by 10% over current which is 0 Data Source: EHR, or electronic referral processing system; encounter records from telemedicine program Milestone 6 Estimated Incentive Payment $59,650
<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated Milestone Bundle Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>$61,920.00</td>
</tr>
<tr>
<td>Year 3</td>
<td>$134,790.00</td>
</tr>
<tr>
<td>Year 4</td>
<td>$133,940.00</td>
</tr>
<tr>
<td>Year 5</td>
<td>$119,300.00</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $449,950.00
Fort Bend County Clinical Health Services
Pass 1
Project Summary – Fort Bend County 2967606-01 1.1
Development of behavioral health crisis stabilization services as alternatives to hospitalization – Behavioral Health Crisis Response and Intervention

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

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

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

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

Category 1 patient benefit milestones: FBC expects to see a reduction in the percentage of patients with behavioral health needs that are incarcerated, or who access EMS and emergency departments. A 10% (160 individuals) decrease in mental health admission and readmissions to criminal justice settings (jail) is expected in DY 4 and 15% in DY5 and 1600 individuals will receive crisis intervention and/or follow-up services by the specialized FB CIT. Based on data from emergency department admissions, more than 55% of the patients for all categories are either Medicaid recipients or uninsured/underinsured. It is anticipated that an even higher percentage of the mental health admissions are in this category.

Category 3 outcome measures: IT 9.2 Reduce emergency visits for behavioral health/substance abuse by 10%.
Project Option 1.13.1 - Develop behavioral health crisis stabilization services as alternatives to hospitalization: Fort Bend County Behavioral Health Crisis Response and Intervention

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

Project Description:

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

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

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

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

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

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

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

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

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

This project meets the following Region 3 goals:
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure that is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction;
• Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay; and,
• Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

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

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

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

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

<table>
<thead>
<tr>
<th>77053</th>
<th>77406</th>
<th>77407</th>
<th>77417</th>
<th>77441</th>
<th>77444</th>
</tr>
</thead>
<tbody>
<tr>
<td>77451</td>
<td>77459</td>
<td>77461</td>
<td>77464</td>
<td>77469</td>
<td>77471</td>
</tr>
<tr>
<td>77476</td>
<td>77477</td>
<td>77478</td>
<td>77479</td>
<td>77481</td>
<td>77487</td>
</tr>
<tr>
<td>77489</td>
<td>77494</td>
<td>77496</td>
<td>77497</td>
<td>77498</td>
<td>77545</td>
</tr>
</tbody>
</table>
**Starting Point/Baseline:**
Currently a Crisis Response and Intervention program, focusing on 911 dispatch, specialized law enforcement training, and increased community services and supports, does not exist. This is a new program; therefore, the baseline for all metrics and milestones will be established after the project is implemented.

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

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

a. Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps. A great deal of work has been done by FBC through the Criminal Justice Mental Health Initiative during the past 4 years with a focus in the past year on the development of law enforcement Crisis Intervention Team and additional behavioral health services.

b. Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria, and discharge criteria for each service.

c. Assess the behavioral health needs of patients currently receiving crisis services in the jails, emergency departments, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients (e.g., a minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming ER settings). FBC has developed data tracking systems for the jail and EMS that allow us to identify persons with behavioral health needs and determine their use of jail and emergency rooms. FBC has worked extensively with various county departments and the Sheriff’s Office to identify and assess behavioral health needs of patients in the jail. The FBC project will expand on this work.

d. Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.

e. Review the impact of intervention(s) on access to and quality of behavioral health crisis stabilization services, and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.
**Milestones & Metrics:**

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

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

Since this is a start-up project and these services are not available, all of these milestones/metrics are necessary for a successful project.

The following improvement milestone and metrics were chosen:

**I-10.1**: 10% decrease in mental health admission and readmissions to criminal justice settings such as jails or prisons in DY 4 and 15% in DY 5.

The proposed project focusing on the development of a coordinated crisis response system in Fort Bend County, which includes the development of a Crisis Intervention Team, has the main objective of connecting persons with appropriate services and preventing unnecessary incarceration and emergency room utilization. Interventions that prevent individuals from entering and/or cycling through the criminal justice system, such as CIT, can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning. This milestone was chosen to ensure that the FBC Behavioral Health Crisis Response and Intervention Project is responding appropriately to crisis calls and diverting them from jails and unnecessary hospitalization. Based on data from emergency department admissions, more than 55% of the patients for all categories are either Medicaid recipients or uninsured / underinsured. It is anticipated that an even higher percentage of the mental health admissions are in this category.

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

This is a new initiative for FBC and will improve response to patients with behavioral health needs. In addition, this initiative will further the development of needed infrastructures and partnerships to leverage existing resources, develop additional resources based on identified needs, and improve access to care in the community.

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

The Category 3 Outcome Measure chosen falls within OD-9-Right Care, Right Setting.

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

The goal of the FBC project is to divert persons experiencing behavioral health crisis from the incarceration and unnecessary use of emergency departments. The FBC project will focus on the identification of behavioral health crisis, triage and appropriate intervention from the onset of the 911 call followed by the referral to the specialized CIT team and follow-up services. This will divert persons with behavioral health needs to the appropriate services as opposed to EMS transports and admissions to the ER or jails.
**Relationship to Other Projects:** This project will interface with Crisis Stabilization projects proposed by Texana. Once a law enforcement team is trained to recognize mental illness and appropriate law enforcement interventions to use for this population, they must have a place to take these individuals other than the jail and emergency rooms for complete evaluation and assessment. The proposed Crisis Stabilization Center will be a critical component to the development of a “coordinated crisis response and intervention” system.

This project will also interface with other FBC projects such as Expanding Primary Care, Care Coordination, and the Community Paramedic Program. All of these will facilitate access to essential primary care, which is often overlooked for persons with behavioral health disorders.

**Relationship to Other Performing Providers’ Projects in the RHP:**
The FBC project will interface with other Performing Provider’s (PP’s) in the region to ensure access to necessary behavioral health services to prevent admissions and readmissions to the jail as well as the unnecessary use of the emergency rooms (e.g., Oak Bend Hospital).

Numerous community needs assessments reflect an extreme need for behavioral health services to include outpatient treatment centers, crisis stabilization units, inpatient beds, and much more. The lack of funding as well as complexity of the regions patient base has limited the amount of behavioral health treatments available to our region and continues to drive cost in emergent and inpatient situations. The Crisis Stabilization Unit has a direct correlation to all behavioral health programs recommended in the RHP plan and will be a focus of two of the largest Local Mental Health Authorities of our region. Both CSU's share the outcome measures of mental health admissions & readmissions, and improvement of patient satisfaction scores. The Region 3 Initiative Grid attached in the addendum reflects the direct relationships of this initiative.

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

**Project Valuation:** This project addresses the top priority identified by the FBC 1115 planning group – a system for responding to behavioral health crises and providing appropriate care. This project addresses key components of the “community crisis system” by enhancing the county’s dispatch system, cross training dispatchers, law enforcement, EMS and other first responders, developing a specialized law enforcement team (CIT), and developing protocols and systems to connect patients with the most appropriate care in a timely manner. The project was valued based on cost-avoidance by projecting savings associated with incarceration and unnecessary use of emergency departments by patients in Fort Bend County with behavioral health needs. FBC has analyzed data from EMS and the Sheriff’s Office for the past several years to determine the number of persons with behavioral health crises that access those systems. Annual cost savings are estimated to be: $450k for avoided ER visits to Oak Bend; $1.8m in avoided incarceration costs; $560k for avoided EMS calls; $1.2m for avoided State Hospital visits; and $80k for avoided transports by law enforcement. This program is projected to avoid costs totaling $4.1m annually or $16.4m over four years.
<table>
<thead>
<tr>
<th>Milestone 1 [P-2]: Conduct mapping and gap analysis of current crisis system.</th>
<th>Milestone 3 [P-4]: Hire and train staff to implement identified crisis stabilization services.</th>
<th>Milestone 5 [P-9]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around similar or shared projects.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [P-2.1]: Produce a written analysis of community needs for crisis services.</td>
<td>Metric 1 [P-4.1]: Number of staff hired and trained. Baseline/Goal: TBD/Goal is to hire and train 9 CIT staff. Goal is to train 23 (50% of workforce) 911 dispatchers. Data Source: Training curricula, training logs, training evaluation</td>
<td>Metric 1 [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Promote continuous learning and best practices in twice yearly meetings. Data Source: Documentation of semiannual face-to-face meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
</tr>
<tr>
<td>Baseline/Goal: TBD/Analysis of Fort Bend County crisis services Data Source: Written report</td>
<td>Baseline/Goal: TBD/Goal is to hire and train 9 CIT staff.</td>
<td>Baseline/Goal: Promote continuous learning and best practices in twice-yearly meetings. Data Source: Documentation of semiannual face-to-face meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $1,037,413</td>
<td>Process Milestone 3 Estimated Incentive Payment: $1,063,323</td>
<td>Process Milestone 5 Estimated Incentive Payment: $1,180,609</td>
</tr>
<tr>
<td>Milestone 2 [P-3]: Develop implementation plans for needed crisis services.</td>
<td>Milestone 4 [P-5]: Develop administration of operational protocols and clinical guidelines for crisis services.</td>
<td>Milestone 6 [I-10]: Criminal Justice Admissions / Readmissions</td>
</tr>
<tr>
<td>Metric 1 [P-3.1]: Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community based on gap analysis and assessment of needs. Baseline/Goal: Action plan based on needs assessment Data Source: Written implementation/ action plans</td>
<td>Metric 1 [P-5.1]: Completion of policies and procedures Baseline/Goal: Develop agreed upon guidelines for crisis services Data Source: Fort Bend County operational and clinical guidelines manuals for crisis services</td>
<td>Metric 1 [I-10.1]: 10% decrease in mental health admission and readmissions to criminal justice settings such as jails or prisons in DY4 Baseline/Goal: TBD / 10% decrease</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $1,037,413</td>
<td>Process Milestone 4 Estimated Incentive Payment: $1,063,322</td>
<td>Process Milestone 7 Estimated Incentive Payment: $1,138,667</td>
</tr>
<tr>
<td>Milestone 7 [P-9]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around similar or shared projects.</td>
<td>Milestone 8 [I-10]: Criminal Justice Admissions / Readmissions</td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Promote continuous learning and best practices in twice yearly meetings. Data Source: Documentation of semiannual face-to-face meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>Metric 1 [I-10.1]: 15% decrease in mental health admission and readmissions to criminal justice settings such as jails or prisons in DY5 Baseline/Goal: DY4 Baseline / 15% decrease</td>
<td></td>
</tr>
<tr>
<td>2967606-01 1.1</td>
<td>1.13.1</td>
<td>(A–E)</td>
</tr>
<tr>
<td>---------------</td>
<td>--------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measures</th>
<th>2967606-01 3.1</th>
<th>IT-9.2</th>
<th>ED Appropriate Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Year 4** (10/1/2014 – 9/30/2015)  | a. 160 individuals will be diverted from admission/to the FBC jail within DY 4.  
b. 1600 individuals will receive crisis intervention and/or follow-up services by the specialized FB CIT.  
Data Source: CIT reports, jail data, clinical records  
Milestone 6 Estimated Incentive Payment: $1,180,608 |
| **Year 5** (10/1/2015 – 9/30/2016)  | a. 240 individuals will be diverted from admission/to the FBC jail within DY 5.  
b. 1600 individuals will receive crisis intervention and/or follow-up services by the specialized FB CIT.  
Data Source: CIT reports, jail data, clinical records  
Milestone 8 Estimated Incentive Payment: $1,138,666 |

| Year 2 Estimated Milestone Bundle Amount: $2,074,826 | Year 3 Estimated Milestone Bundle Amount: $2,126,645 | Year 4 Estimated Milestone Bundle Amount: $2,361,217 | Year 5 Estimated Milestone Bundle Amount: $2,277,333 |

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $8,840,021
Fort Bend County Clinical Health Services
Pass 3
**Project Summary - Fort Bend County 2967606-01.1.2**

**Expand Existing Primary Care Capacity – Expand Hours of Service**

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

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

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

**Target Population:** Uninsured, underinsured and Medicaid covered individuals who do not access primary care and use emergency services in lieu of a medical home. Patients will receive the benefit of ongoing assistance with medical care for primary care, prevention and chronic conditions as well as being linked to needed social services and transportation. It is expected that in the first year of implementation the new patient care team will see 65% of the current patient load of a full time provider panel (care team), therefore seeing 975 patients in DY3. In DY4 and DY5, it is anticipated that the new care team will see 1,500 patients each year.

**Category 1 patient benefit milestones:** The program will divert patients from high cost EMS transportation and ED visits to the FQHC medical home. An anticipated 975 patients will be served in DY3 and 1,500 in DY4 and DY5.

**Category 3 outcome measures:** IT 1.1 – 10% (DY4) and 20% (DY5) reduction in third next appointment interval in the target population. IT 9.2 - 25% (DY4) and 30% (DY5) reduction in ED use in the target population.
Project Option 1.1.2 – Expand Existing Primary Care Capacity – Expand Hours of Service

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

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

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

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

**Target Zip codes for the program are:**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>77053</td>
<td>77406</td>
<td>77407</td>
<td>77417</td>
<td>77441</td>
<td>77444</td>
</tr>
<tr>
<td>77451</td>
<td>77495</td>
<td>77461</td>
<td>77464</td>
<td>77469</td>
<td>77471</td>
</tr>
<tr>
<td>77476</td>
<td>77477</td>
<td>77478</td>
<td>77479</td>
<td>77481</td>
<td>77487</td>
</tr>
<tr>
<td>77489</td>
<td>77494</td>
<td>77496</td>
<td>77497</td>
<td>77498</td>
<td>77545</td>
</tr>
</tbody>
</table>

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

The project meets the following regional goals:
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.
Challenges:
The populations that this project seeks to serve have established patterns of behavior that are not conducive to improved health or to cost effective use of existing medical resources. As with any intervention that seeks to change current behavior, the project will need to be patient centered and be flexible to encourage the change in behavior that is desired. Data collection for baseline and rapid cycle evaluation will need to come from a variety of providers and agencies and will need a systematic collection methodology.

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

Starting Point/Baseline:
Baseline data is not established, although community partners and the FQHC have some data points as background rationale for the project. Data will be gathered on past and current users of the FQHS, the EMS transportation system, hospital EDs and the Fort Bend County Indigent Care program for non-emergent and for frequent users of the high-end resources to establish the patterns of resource use as a starting point for the proposed program. In the first six months of the program, data gathering systems will be put in place to monitor the successful referral and engagement of patients from the target populations. It is expected that in the first year of implementation the new patient care team will see 65% of the current patient load of a full time provider panel (care team), therefore seeing 975 patients in DY3. In DY4 and DY5, it is anticipated that the new care team will see 1,500 patients each year.

Rationale:
Fort Bend County does not have a hospital district structure for indigent healthcare or for the uninsured and underinsured population of the County. The County participates in the state mandated Indigent Health Care Program which provides care for qualifying individuals whose income is below 22% of the Federal Poverty Level. With a population estimate of 606,000, there are more than 48,500 (8%) individuals living below the Federal Poverty Level and up to 145,000 uninsured at this time in the County1. For these individuals, medical care is often beyond their economic reach. Cash payment options and even sliding scale fees take lower priority than housing payments and food. One of the ways that the indigent population of the County avoids payment up front is to utilize the EMS 9-1-1 response system to obtain a “free” ride to the hospital, to receive priority care in the Emergency Department because of EMS transport and to not have a co-pay on site at the hospital.

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

Along with the use of expensive EMS and ED services for non-emergent illnesses, is the use of these same resources for chronic conditions which could better be managed and controlled
in an outpatient setting using a medical home approach. Barriers to patients voluntarily seeking this option include lack of knowledge and understanding of their own medical conditions and of the resources available, lack of transportation, inability to pay fees and available hours for care.

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

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

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

**Project Components:**

Required core project components: 1.1.2

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

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

b) Expand primary care clinic hours

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

c) Expand primary care clinic staffing

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

**Milestones and Metrics:**

Process Milestones and Metrics

P-X. Milestone: Conduct a needs assessment to determine the targeted population and provider team configuration. (Metric P-X.1)

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

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

Improvement Milestones and Metrics

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

I-15. Milestone: Increase access to primary care capacity. (Metric I-15.1)
Unique community need identification number the project addresses:

- CN.7 Insufficient access to care coordination practice management and integrated care treatment programs.
- CN.8 High rates of inappropriate emergency department utilization
- CN.9 High rates of preventable hospital admissions
- CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease

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

This project uses the existing medical practice in the local FQHC and expands the available hours of access to primary care at the clinic. It additionally provides access to the care coordination protocol for those traditionally not involved in coordinated care systems which can lead to improved health outcomes and reduction in encounters with EMS and the ED.

This project will involve providing funding to the FQHC to expand the staffing available by one team of providers and support staff. This will allow an increase in the hours of operation for patients who will be referred to the FQHC as their medical home. Federal funding will not be used to expand the number of staff involved in patient care related to this project.

Related Category 3 Outcome Measures:

OD-1 Primary and Chronic Disease Management (IT 1.1 – Third Next Available Appointment)
OD-9 Right Care, Right Setting (IT 9.2 – ED Appropriate Utilization / Reduce ED use in target population referred to Care Coordination Program)

Reasons/Rationale for selecting the outcome measures:

The target populations of Medicaid patients, County Indigent Care patients, uninsured or underinsured patients have habitually used high end medical resources such as the ED due to lack of financial resources to pay for medical care, or lack of access to primary care sites in the evenings or on weekends. The measures will allow measurement of improvements in access and reduction in use of the ED.

Relationship to other Projects:

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

Relationship to Other Performing Providers’ Projects in the RHP:

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

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

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

References:
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th><strong>B AND C</strong> EXPAND PRIMARY CARE CAPACITY (EXPAND HOURS OF SERVICE AND EXPAND STAFFING)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fort Bend County</strong></td>
<td>2967606-01 3.10</td>
<td>IT 1.1.2: Third Next Available Appointment ED Appropriate Utilization</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Milestone 1</strong> [P-X]: Planning stage for expansion of hours.</td>
<td><strong>Milestone 2</strong> [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours. Anticipate 975 additional patient visits in DY5 due to new provider team.</td>
<td><strong>Milestone 4</strong> [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours. Anticipate 1,500 additional patient visits in DY4 due to new provider team.</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-X.1]: Conduct needs assessment to determine the following:</td>
<td><strong>Metric 1</strong> [P-4.1]: Increased number of hours at clinic over baseline</td>
<td><strong>Metric 1</strong> [P-4.1]: Increased number of hours at clinic over baseline (maintain as in DY3)</td>
</tr>
<tr>
<td>• Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy).</td>
<td>Baseline: DY2 hours of operation Goal: increase hours to 7am to 7pm weekdays and include Saturday hours Data Source: Clinic documentation</td>
<td>Baseline: DY2 hours of operation Goal: increase hours to 7am to 7pm weekdays and include Saturday hours Data Source: Clinic documentation</td>
</tr>
<tr>
<td>• Gaps in services and service needs.</td>
<td><strong>Metric 1</strong> [P-5.1]: Documentation of increased number of providers and staff</td>
<td>Baseline: TBD Goal: - Increase number of providers to cover expanded hours of clinic operation Data Source: Clinic documentation</td>
</tr>
<tr>
<td>• Structure of coverage teams</td>
<td>Baseline: DY3 number of providers and staff Goal: - Maintain number of providers to cover hours of clinic operation as in DY3</td>
<td>Baseline: TBD Goal: - Increase number of providers to cover expanded hours of clinic operation Data Source: Clinic documentation</td>
</tr>
<tr>
<td>• Ideal number of medical providers needed for the expanded hours.</td>
<td><strong>Metric 1</strong> [P-5.1]: Documentation of increased number of providers and staff</td>
<td><strong>Baseline: DY3 number of providers and staff Goal: - Maintain number of providers to cover hours of clinic operation as in DY3</strong></td>
</tr>
<tr>
<td>• Number of support staff needed to be hired</td>
<td><strong>Milestone 3</strong> [P-5]: Train/hire additional primary care providers and staff</td>
<td><strong>Milestone 5</strong> [P-5]: Train/hire additional primary care providers and staff</td>
</tr>
<tr>
<td>• Establish third next appointment baseline</td>
<td><strong>Metric 1</strong> [P-5.1]: Documentation of increased number of providers and staff</td>
<td><strong>Metric 1</strong> [P-5.1]: Documentation of increased number of providers and staff</td>
</tr>
<tr>
<td>Goal: To produce a report including the above data for program planning and implementation Data Source: Program documentation, EHR, claims, needs assessment survey, partner organization data</td>
<td><strong>Milestone 2 Estimated Incentive Payment: $229,941</strong></td>
<td><strong>Milestone 4 Estimated Incentive Payment: $251,275</strong></td>
</tr>
<tr>
<td><strong>Milestone 1 Estimated Incentive Payment: $405,096</strong></td>
<td><strong>Milestone 3 Estimated Incentive Payment: $251,275</strong></td>
<td><strong>Milestone 5 Estimated Incentive Payment: $251,275</strong></td>
</tr>
</tbody>
</table>
| **2967606-01 1.2** | **1.1.2** | **B AND C** | **EXPAND PRIMARY CARE CAPACITY**  
**EXPAND HOURS OF SERVICE AND EXPAND STAFFING** |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fort Bend County</strong></td>
<td>2967606-01</td>
<td>2967606-01</td>
<td><strong>2967606-01</strong></td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s):</strong></td>
<td><strong>IT 1.1</strong></td>
<td><strong>IT 9.2</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Milestone 3 Estimated Incentive Payment $229,941</strong></td>
<td><strong>Data Source: Clinic documentation</strong></td>
<td><strong>Milestone 5 Estimated Incentive Payment $251,274</strong></td>
<td><strong>Data Source: Clinic documentation</strong></td>
</tr>
<tr>
<td><strong>Milestone 8 [I-13]: Enhanced Capacity to provide urgent care services in the Primary Care setting.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1 [I-13.1]: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 2 calendar days of request</strong></td>
<td><strong>Baseline: TBD determined for DY3</strong></td>
<td><strong>Goal: 10% improvement in receiving urgent care appointment in primary care setting</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 14 Estimated incentive Payment $161,124</strong></td>
<td><strong>Year 2 Estimated Milestone Bundle Amount: $405,096</strong></td>
<td><strong>Year 3 Estimated Milestone Bundle Amount: $459,882</strong></td>
<td><strong>Year 4 Estimated Milestone Bundle Amount: $502,549</strong></td>
</tr>
<tr>
<td><strong>Year 5 Estimated Milestone Bundle Amount: $483,372</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add milestone bundle amounts over DYs 2-5): $1,850,899</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Gulf Coast Medical Center
Pass 1
Project Option 1.9.2-Expand Specialty Care Capacity: Establish Adult Inpatient Psychiatric Unit

**Unique RHP Project ID:** 178815001.1.1  
**Performing Provider Name/TPI:** Gulf Coast Medical Center/178815001

**Project Summary:**

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

**Intervention(s):**
This project will establish a 28 bed adult inpatient psychiatric unit within Gulf Coast Medical Center which will be dedicated to the treatment of general psychiatric disorders for the age population of 18 through 64 years of age and evaluate outpatient center development for follow up care.

**Need for the Project:**
Wharton County and the surrounding rural area are currently underserved with regard to Psychiatric Care. In addition, finding an accepting facility for those patients presenting to the Emergency Department (ED) in need of inpatient psychiatric treatment is most difficult. Treatment delay has been known to occur frequently due to lack of beds at treatment facilities which require patients to remain in our ED until such time that a bed is secured and transfer can occur.

**Target Population:**
All patients requiring inpatient level of care for the treatment of psychiatric disorders from within Wharton County and the surrounding rural areas may benefit from this project. Currently no baseline data is available as inpatient psychiatric treatment facilities are non existent in the County.

**Category 1 Expected Patient Benefits:**
Our goal is to implement a process by which referrals are processed in a timely for inpatient psychiatric admission to prevent delay of treatment. Baseline will be established in DY 2 with a time improvement DY 3, 4, and 5. In addition, average daily census will improve DY 3, 4, and 5 as compared to baseline established in DY2.

**Category 3 Outcomes:**
IT-1.18 Our goal is to improve follow up rates with mental health practitioner by 5% in DY4 and 10% in DY5 as compared to baseline which will be established in DY3.
IT-1.20  Our goal is to improve timeliness of inpatient admission for mental illness by % of increase of admission rate DY4 and DY 5 as compared to baseline established in DY 3.
Project Option 1.9.2- Expand Specialty Care Capacity: Establish Adult Inpatient Psychiatric Unit

**Unique RPH Provider Identification Number:** 178815001.1.1

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

**Project Description:**

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

The performing provider is currently in the planning stages of establishing a 28 bed adult psychiatric unit dedicated to the treatment of general psychiatric disorders. Current challenges facing the provider include the lack of adult inpatient psychiatric care within Wharton County and the surrounding rural areas. In addition, finding an accepting facility for inpatient treatment for this diagnosis specific population is most difficult. Treatment delay is common with the psychiatric patient remaining in the Emergency Department until such time that a bed becomes available and the transfer is secured. This delay in care has been noted to be greater than 60 hours in some cases. The addition of an inpatient adult psych unit aligns with the regional goal of increasing access to specialty services and to ensure patients receive the most appropriate care for their condition. Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. To achieve success as an integrated network, gaps must be thoroughly assessed and addressed. The expected outcome of the project allows for the treatment of psychiatric disorders of adult patients requiring inpatient level of care within Wharton County. Currently specialty treatment on an inpatient level for psychiatric conditions is non existent for the adult patient population less than 65 years of age. At capacity, (aggressive growth DY2 through DY5) this project would allow for 10,080 patient days of inpatient community based psychiatric care within a rural underserved geographical area with extremely limited current access to care available. There is potential by DY5 of the project to provide specialized psychiatric care to 760 under-served individuals.

**Goal(s) and Their Relationship to Regional Goals:**

The goal of this project is to provide inpatient level of psychiatric care for the adult patients in Wharton County and the surrounding rural areas.

**Project Goals:**

- Provide inpatient psychiatric care to the adult population by establishing an inpatient Psych Unit with 44 28 beds designated for the treatment of general psychiatric disorders.

This project meets the following Region 3 goals:

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

**Challenges:**

Wharton County and the surrounding rural area are currently underserved with regard to Psychiatric Care. Information obtained from the United States Census Bureau for 2011 the population of Wharton County is estimated at 41,314. Of those, approximately 58.50% are between the ages of 18 and 65 (this does not include the census of the surrounding areas). Although this total will not require treatment for psychiatric disorders the potential for need has
been observed and witnessed frequently in the Emergency Department of Gulf Coast Medical Center. The challenge of obtaining the most appropriate care for their condition as noted in the regional goals is being experienced firsthand.

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

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

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

- a) Increase service availability with extended hours
- b) Increase number of specialty clinic locations
- c) Implement transparent, standardized referrals across the system.
- d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but not limited to, identifying project impacts, “lessons learned”, opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

**Milestones and Metrics:**
The following milestones and metrics have been chosen for the Establishment of an Adult Inpatient Psychiatric Unit:
- Process Milestones and Metrics: P-1 (P-1.1); P-2 (P-2.1); P-4 (P-4.2); P-5 (P-5.1); P-21 (P-21.1)
- Improvement Milestone and Metrics: I-33 (LW1)
- Improvement Target and Metrics: OD-1 (IT-1.18); (IT-1.20)

**Unique Community Needs Identification Number the Project Addresses:**
The project addresses the following unique community needs as identified in the community needs assessment:
- CN.2 Inadequate access to specialty care
- CN.3 Inadequate access to behavioral health care

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

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

Related Category 3 Outcome Measures:
OD-1 Primary Care and Chronic Disease Management
IT-1.18 Follow-up after Hospitalization for Mental Illness—NFQ 0576
- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge.
- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge.
IT-1.20 Timeliness of Inpatient Admission for Mental Illness (referral/admission to Unit).

Reasons/Rational for Selecting the Outcome Measure:
Follow up after hospitalization for mental illness was selected as the Category 3 outcome measure by this performing provider to ensure that the treatment plan established for the patient prior to discharge continues through the continuum of care for outpatient care. Non compliance for follow up care on an outpatient basis results in possible readmission. With utilization of discharge planning to evidenced based partial hospitalization or other intensive outpatient services follow-up; patients are treated at a lower cost as well as being monitored for earlier intervention thereby reducing preventable re-admissions. The less time lapse between service levels of care the greater the likelihood of successful patient engagement in the treatment process and therefore more efficacy in terms of long-term clinical outcomes. In addition, the necessity of a fast track approach from referral to admission/arrival on the unit is of utmost importance to avoid delay in the initiation of treatment. Delays in the initiation of psychiatric treatment services may result in otherwise avoidable exacerbations of symptoms and behaviors that may result in multiple complications including costly medical and/or legal elements/interventions.

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

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

**Plan for Learning Collaborative:**

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

**Project Valuation:**

The following allocation for DY 2 through DY 5 is as follow for a total of $3,823,217:

<table>
<thead>
<tr>
<th>Year</th>
<th>Allocation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y2</td>
<td>936,218</td>
<td>72%</td>
</tr>
<tr>
<td>Y3</td>
<td>1,007,685</td>
<td>65%</td>
</tr>
<tr>
<td>Y4</td>
<td>1,077,987</td>
<td>51%</td>
</tr>
<tr>
<td>Y5</td>
<td>801,327</td>
<td>51%</td>
</tr>
</tbody>
</table>

Areas considered when allocating funds for this project included the importance of ensuring individuals within Wharton County and the surrounding rural areas as well as the military the care needed with regard to mental disorders. A 28 - bed inpatient adult psychiatric unit would allow individual’s timely access to care for mental disorders whereas currently delay in care is experienced frequently as bed availability is limited and waiting lists for beds are being utilized.
<table>
<thead>
<tr>
<th>Goal: Produce a comprehensive report documenting all points noted above. Data Source: Potential management company documentation; AIA architect discussion;</th>
<th>Goal: Produce a comprehensive report documenting all points noted above. Data Source: Potential management company documentation; AIA architect discussion;</th>
<th>Goal: Produce a comprehensive report documenting all points noted above. Data Source: Potential management company documentation; AIA architect discussion;</th>
<th>Goal: Produce a comprehensive report documenting all points noted above. Data Source: Potential management company documentation; AIA architect discussion;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $503,842.5</td>
<td>Milestone 5 Estimated Incentive Payment: $503,842.5</td>
<td>Milestone 9 Estimated Incentive Payment: $503,842.5</td>
<td>Milestone 12 Estimated Incentive Payment: $503,842.5</td>
</tr>
<tr>
<td>Milestone 6 Estimated Incentive Payment: $359,329.00</td>
<td>Milestone 10 Estimated Incentive Payment: $359,329.00</td>
<td>Milestone 13 Estimated Incentive Payment: $359,329.00</td>
<td>Milestone 14 Estimated Incentive Payment: $359,329.00</td>
</tr>
</tbody>
</table>
| Related Category 3 Outcome Measure(s): | 178815001.1.1 | 1.9.2 | 1.9.2(A-D) | EXPAND SPECIALTY CARE CAPACITY
ESTABLISH ADULT INPATIENT PSYCHIATRIC UNIT |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gulf Coast Medical Center</td>
<td>178815001.3.1</td>
<td>IT-1.18</td>
<td>IT-1.20</td>
<td>178815001</td>
</tr>
<tr>
<td>Follow up after Hospitalization for Mental Illness</td>
<td>178815001.3.2</td>
<td>IT-1.18</td>
<td>IT-1.20</td>
<td>Timeliness of Inpatient Admission for Mental Illness (referral/admission to Unit)</td>
</tr>
</tbody>
</table>

**Year 2**
(10/1/2012 – 9/30/2013)

Payment: $500,000 $312,072.67

**Milestone 2 [P-2.1]:** Train care providers and staff on processes guidelines for referrals and consultations into selected medical specialties.

**Metric 1 [P-2.1]:** Number of staff trained and documentation of training materials.

Goal: Establish/process for training/guidelines for seamless referral and acceptance of patients to the psychiatric unit. Establish baseline to develop target time from referral to admission in DY 3.

Data Source: Training materials

Milestone 5 Estimated Incentive Payment: $503842.5

**Year 3**
(10/1/2013 – 9/30/2014)

Metric 1 [P-21.1]: Participate in semi-annual face to face meetings or seminars organized by the RHP.

Goal: Participate in all semi annual face to face meetings or seminars.

Data Source: Documentation of semi-annual meetings to include agenda, presentation info

Milestone 7 Estimated Incentive Payment: $359,329.00

**Year 4**
(10/1/2014 – 9/30/2015)

Metric 1 [P-5.1]: Generate and provide report on average referral process time from receipt of referral to inpatient hospitalization.

Baseline/Goal: Baseline will be established in DY 2.

Goal: Improve rate for DY 4 as compared to DY 2. Increase patient admission rate by 5%.

Data Source: Generated reports on file.

Milestone 8 Estimated Incentive Payment: $359,329.00

**Year 5**
(10/1/2015 – 9/30/2016)

Metric 1 [P-5.1]: Generate and provide reports on average referral process time from receipt of referral to inpatient hospitalization.

Baseline/Goal: Baseline will be established in DY 2.

Goal: Improve rate for DY 5 as compared to DY 2. Increase patient admission rate to an average daily census by 8%.

Data Source: Generated reports on file.

Milestone 10 Estimated Incentive Payment: $267,109

**Milestone 11 [I-33]:** Increase specialty care capacity by expanding adult psychiatric services unit.

Metric 1 [I-33.1]: Increase percentage of target population reached.

Baseline/Goal: Increase by 5%.

Data Source: Reports and data collection

Milestone 11 Estimated Incentive Payment $267,109
| **178815001.1.1** | **1.9.2** | **1.9.2(A-D)** | **EXPAND SPECIALTY CARE CAPACITY**<br>**ESTABLISH ADULT INPATIENT PSYCHIATRIC UNIT**
Gulf Coast Medical Center | 178815001 |
|---|---|---|---|
| **Related Category 3**<br>**Outcome Measure(s):** | **178815001.3.1**<br>**178815001.3.2** | **IT-1.18**<br>**IT-1.20** | **Follow up after Hospitalization for Mental Illness**<br>**Timeliness of Inpatient Admission for Mental Illness (referral/admission to Unit)**
| **Goal:** Develop a robust referral management plan in which referrals are processed, patient screened, and placement of patient in psychiatric care is done in a timely manner.<br>**Data Source:** Written description of the process of managing referral into the inpatient adult psychiatric unit. | **Milestone 3 Estimated Incentive Payment:** $312,072.67 | **Year 2 Estimated Outcome Amount:** $936,218 (72%)<br>(10/1/2012 – 9/30/2013) | **Year 3 Estimated Outcome Amount:** $1,007,685 (65%)<br>(10/1/2013 – 9/30/2014) | **Year 4 Estimated Outcome Amount:** $1,077,987 (51%)<br>(10/1/2014 – 9/30/2015) | **Year 5 Estimated Outcome Amount:** $801,327 (51%)<br>(10/1/2015 – 9/30/2016) |
| **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over D_Ys 2-5): $3,823,217 |  |  |  |  |  |
Harris County Hospital District Ben Taub General Hospital
Pass 1
Project Option 1.1.1- Establish more primary care clinics: Gulfgate Area Same Day Access Clinic

Unique RHP Project ID: 13335104.1.1 / Pass 1
Performing Provider Name/TPI: Harris Health System / 13335104

Project Summary:

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

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

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

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

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

Category 1 or 2 expected patient benefits:
Our goals are to see 1,000 completed visits in DY3, 10,000 in DY4, and 20,000 in DY5, for a total of 31,000 visits from DY3-DY5.

Category 3 outcomes:
IT 6.2- Other: Percent improvement over baseline of Patient Satisfaction scores: 0.5% improvement in DY4 and 1% improvement in DY5.
Project Option 1.1.1- Establish more primary care clinics: Gulfgate Area Same Day Access Clinic

**Unique RHP Project ID:** 133355104.1.1 / Pass 1  
**Performing Provider Name/TPI:** Harris Health System / 133355104

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

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

**Goals and Relationship to Regional Goals:**
The goals of this project are to:
- Increase capacity for same day primary care through establishment of more accessible care locations across Harris County
- Increase access to same day primary care during extended hours and weekends

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

This project meets the following Region 3 goals:
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

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

**Challenges and how to address:**
General primary care capacity has been a challenge for the Harris Health System. The same day access clinic will provide same day access for Medical Home and non-Medical Home patients. A significant challenge for the Harris Health System has been adequate capacity to offer Medical Homes for patients who do not have a primary care provider. As patients are seen in the same day clinic setting, this will continue to be a problem for those patients who need care for chronic conditions or other specialized care. To address these challenges we propose to direct patients
with chronic conditions into the Medical Home setting at a Harris Health System health center or refer to a primary care settings, such as local FQHCs.

**5-Year Expected Outcome for Provider and Patients:**
Over the course of the 5-Year Waiver, Harris Health System expects to realize:
- Increased adult-focused primary care capacity through same day care clinics for primary care treatable conditions

**Starting Point/Baseline:**
For performance purposes, the baseline will be set at 0 visits since this is a new clinic that currently is not operational. We expect to see 1,000 visits in the first year of operations (DY3).

**Rationale:**
**Reasons for selecting the project option:**
Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health health centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For the Gulfgate health center, there were 792 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. Gulfgate received 144 Ask My Nurse requests per month for patients that needed same day appointments that could not be scheduled by the Patient Appointment Center. Within the Harris Health System, 26% of all requests received in September 2012 for Family Practice appointments that could not be scheduled were for patients living in zip codes served by the Gulfgate health center. These numbers, however, do not capture the full volume of unmet demand due to the fact that some calls were dropped as patients were placed on hold and some patients who needed care did not attempt to obtain an appointment based on previous difficulties obtaining same day appointments. Based on 2012 data of incoming patient calls to the Patient Appointment Center over 22,400 unduplicated patients living near the Gulfgate Health Center were unable to get an appointment.

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

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

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

**Unique community need identification number the project addresses:**
This project addresses the following community needs according to the community needs assessment:
- CN.1- Inadequate access to primary care
• CN.8- High rates of inappropriate emergency department utilization
• CN.2- Inadequate access to specialty care

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

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

Related Category 3 Outcome Measure(s):
OD-6 Patient Satisfaction

- IT 6.2- Other: Percent improvement over baseline of Patient Satisfaction scores: 0.5% improvement in DY4 and 1% improvement in DY5.

Reasons/rationale for selecting the outcome measure(s):
The same day access clinic will increase capacity for primary care visits within the Harris Health System, which will enhance access and improve the patient’s experience in obtaining services. Patient satisfaction scores have been historically poor for health centers regarding timely access to care. The same day access clinic will offer an efficient venue that offers same day visits, affording patients the opportunity to seek care in a setting that is appropriate for the level of care they need and more cost effective than other alternatives IT-6.2 was specifically chosen as Harris Health will be using Press-Ganey (approved by HHSC) as the source for survey metrics and results. The survey chosen measures all aspects of a patient visit, and thus will give Harris Health System a comprehensive indication of how we are performing.

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

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.
**Project Valuation:** This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic’s capacity to provide primary care services, including laboratory point-of-care testing, along with timely referrals for specialty care, imaging and other needed services within the Harris Health System network. We expect to achieve optimum capacity and productivity by the end of DY5, ultimately resulting in 20,000 completed visits per year. We will refer new patients with chronic disease management needs to one of the NCQA certified medical home clinics that are operated by Harris Health. In addition, the availability of same day primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>133355104.1.1</td>
<td>IT-6.2</td>
</tr>
</tbody>
</table>

**ESTABLISH MORE PRIMARY CARE CLINICS: GULF GATE AREA SAME DAY ACCESS CLINIC**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1 [P-X]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

**Metric 1 [P-X.1]:** Planning documentation
- Goal: Produce a comprehensive implementation plan for the establishment of same day access clinic
- Data Source: Project plan

**Milestone 1 Estimated Incentive Payment (maximum amount):** $7,132,488

**Milestone 2 [P-1]:** Establish additional primary care clinics

**Metric 1 [P-1.1]:** Number of additional clinics or expanded hours or space
- Baseline: 0 same day access clinics in target area in DY2
- Goal: Establish one same day access clinic
- Data Source: New primary care schedule

**Milestone 2 Estimated Incentive Payment (maximum amount):** $2,593,720

**Milestone 3 [P-5]:** Hire additional primary care providers and staff

**Metric 1 [P-5.1]:** Documentation of increased number of providers and staff
- Baseline: 0 providers and staff hired in DY2
- Goal: Hire 4 Provider FTEs (MD and/or MLP)
- Data Source: Contract documentation

**Milestone 3 Estimated Incentive Payment (maximum amount):**

**Milestone 4 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 [I-12.1]:** Documentation of increased number of visits.
- Goal: 10,000 completed visits in DY4

**Milestone 5 Estimated Incentive Payment (maximum amount):** $7,803,781

**Milestone 5 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 [I-12.1]:** Documentation of increased number of visits.
- Goal: 20,000 completed visits in DY5, for a total of 31,000 completed visits in DY3-5.

**Milestone 6 Estimated Incentive Payment (maximum amount):** $6,446,602
<table>
<thead>
<tr>
<th>133355104.1.1</th>
<th>1.1.1</th>
<th>N/A</th>
<th><strong>Establish more primary care clinics: Gulfgate Area Same Day Access Clinic</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Harris Health System</strong></td>
<td></td>
<td></td>
<td>133355104</td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td><strong>133355104.3.1</strong></td>
<td><strong>IT-6.2</strong></td>
<td><strong>Percent improvement over baseline of patient satisfaction scores</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td><strong>$2,593,720</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Milestone 4 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Metric 1 [I-12.1]: Documentation of increased number of visits.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Baseline: 0 visits in DY1-2</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Goal: 1,000 completed visits.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Data Source: EHR</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Milestone 4 Estimated Incentive Payment (maximum amount):</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>$2,593,721</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone):</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>$7,132,488</strong></td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td><strong>Year 3 Estimated Milestone Bundle Amount: $7,781,161</strong></td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
<td><strong>Year 4 Estimated Milestone Bundle Amount: $7,803,781</strong></td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td><strong>Year 5 Estimated Milestone Bundle Amount: $6,446,602</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $29,164,032</strong></td>
</tr>
</tbody>
</table>
Project Option 1.1.1- Establish more primary care clinics: People’s Area Same Day Access Clinic

Unique RHP Project ID: 133355104.1.2 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104

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

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

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

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

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

Category 1 or 2 expected patient benefits:
Our goals are to see 1,000 completed visits in DY3, 10,000 in DY4, and 20,000 in DY5, for a total of 31,000 visits from DY3-DY5.

Category 3 outcomes:
IT 6.2- Other: Percent improvement over baseline of Patient Satisfaction scores: 0.5% improvement in DY4 and 1% improvement in DY5.
Project Option 1.1.1- Establish more primary care clinics: People’s Area Same Day Access Clinic

**Unique RHP Project ID:** 133355104.1.2 / Pass 1  
**Performing Provider Name/TPI:** Harris Health System / 133355104

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

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

**Goals and Relationship to Regional Goals:**
The goals of this project are to:
- Increase capacity for same day primary care through establishment of more accessible care locations across Harris County
- Increase access to same day primary care during extended hours and weekends

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

This project meets the following Region 3 goals:
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

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

**Challenges and how to address:**
General primary care capacity has been a challenge for the Harris Health System. The same day access clinic will provide same day access for Medical Home and non-Medical Home patients. A significant challenge for the Harris Health System has been adequate capacity to offer Medical Homes for patients who do not have a primary care provider. As patients are seen in the same day clinic setting, this will continue to be a problem for those patients who need care for chronic conditions or other specialized care. To address these challenges we propose to direct patients...
with chronic conditions into the Medical Home setting at a Harris Health System health center or refer to other primary care settings, such as local FQHCs.

**5-Year Expected Outcome for Provider and Patients:**
Over the course of the 5-Year Waiver, Harris Health System expects to realize:
- Increased adult-focused primary care capacity through same day care clinics for primary care treatable conditions

**Starting Point/Baseline:**
For performance purposes, the baseline will be set at 0 visits since this is a new clinic that currently is not operational. We expect to see 1,000 visits in the first year of operations (DY3).

**Rationale:**
**Reasons for selecting the project option:**
Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For the People’s health center, there were 465 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. People’s Health Center received 60 Ask My Nurse requests per month for patients that needed same day appointments that could not be scheduled by the Patient Appointment Center. Within the Harris Health System, 15% of all requests received in September 2012 for Family Practice appointments that could not be scheduled were for patients living in zip codes served by the People’s Health Center. These numbers, however, do not capture the full volume of unmet demand due to the fact that some calls were dropped as patients were placed on hold and some patients who needed care did not attempt to obtain an appointment based on previous difficulties obtaining same day appointments. Based on 2012 data of incoming patient calls to the Patient Appointment Center over 19,200 unduplicated patients living near the People’s Health Center were unable to get an appointment.

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

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

**Milestones & Metrics:**
- Process Milestones and Metrics- P-1 (P-1.1); P-5 (P-5.1); P-X (P-X.1);
  Improvement Milestones and Metrics- I-12 (I-12.1)
Unique community need identification number the project addresses:
This project addresses the following community needs according to the community needs assessment:
• CN.1- Inadequate access to primary care
• CN.8- High rates of inappropriate emergency department utilization
• CN.2- Inadequate access to specialty care

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

Related Category 3 Outcome Measure(s):
OD-6 Patient Satisfaction
IT 6.2- Other: Percent improvement over baseline of Patient Satisfaction scores: 0.5% improvement in DY4 and 1% improvement in DY5.

Reasons/rationale for selecting the outcome measure(s):
The same day access clinic will increase capacity for primary care visits within the Harris Health System, which will enhance access and improve the patient’s experience in obtaining services. Patient satisfaction scores have been historically poor for health centers regarding timely access to care. The same day access clinic will offer an efficient venue that offers same day visits, affording patients the opportunity to seek care in a high-satisfaction setting that is appropriate for the level of care they need and more cost effective than other alternatives. The survey chosen measures all aspects of a patient visit, and thus will give Harris Health System a comprehensive indication of how we are performing.

Relationship to other Projects:
Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.
**Plan for Learning Collaborative:** We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

**Project Valuation:** This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic’s capacity to provide primary care services, including laboratory point-of-care testing, along with timely referrals for specialty care, imaging and other needed services within the Harris Health System network. We expect to achieve optimum capacity and productivity by the end of DY5, ultimately resulting in 20,000 completed visits per year. We will refer new patients with chronic disease management needs to one of the NCQA certified medical home clinics that are operated by Harris Health. In addition, the availability of same day primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>133355104.3.2</th>
<th>133355104.1.2</th>
<th>133355104.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ESTABLISH MORE PRIMARY CARE CLINICS: PEOPLE’S AREA SAME DAY ACCESS CLINIC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3</td>
<td>Outcome Measure(s):</td>
<td>133355104.3.2</td>
<td>133355104.1.2</td>
<td>133355104.1.2</td>
</tr>
<tr>
<td><strong>Milestone 1 [P-X]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</strong></td>
<td><strong>Metric 1 [P-X.1]: Planning documentation</strong></td>
<td>Goal: Produce a comprehensive implementation plan for the establishment of same day access clinic</td>
<td>Data Source: Project plan</td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td><strong>Milestone 2 [P-1]: Establish additional primary care clinics</strong></td>
<td><strong>Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space</strong></td>
<td>Baseline: 0 same day access clinics in target area in DY2 Goal: Establish one same day access clinic for the health center Data Source: New primary care schedule</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Milestone 2 Estimated Incentive Payment (maximum amount):</td>
<td>$2,619,020</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3 [P-5]: Hire additional primary care providers and staff</strong></td>
<td><strong>Metric 1 [P-5.1]: Documentation of increased number of providers and staff</strong></td>
<td>Baseline: 0 providers and staff hired in DY2 Goal: Hire 4 Provider FTEs (MD and/or MLP) Data Source: Contract documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Milestone 3 Estimated Incentive Payment (maximum amount):</td>
<td>$2,619,020</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 4 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</strong></td>
<td><strong>Metric 1 [I-12.1]: Documentation of increased number of visits.</strong></td>
<td>Goal: 10,000 completed visits in DY4 Data Source: EHR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 5 Estimated Incentive Payment (maximum amount):</td>
<td>$7,365,993</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</strong></td>
<td><strong>Metric 1 [I-12.1]: Documentation of increased number of visits.</strong></td>
<td>Goal: 20,000 completed visits in DY5, for a total of 31,000 completed visits in DY3-5. Data Source: EHR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 6 Estimated Incentive Payment (maximum amount):</td>
<td>$5,598,155</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 6 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>133355104.1.2</td>
<td>1.1.1</td>
<td>N/A</td>
<td><strong>ESTABLISH MORE PRIMARY CARE CLINICS: PEOPLE’S AREA SAME DAY ACCESS CLINIC</strong></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
<td>-----</td>
<td>--------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Harris Health System</strong></td>
<td></td>
<td></td>
<td><strong>133355104</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td><strong>133355104.3.2</strong></td>
<td><strong>IT-6.2</strong></td>
<td><strong>Other: Percent improvement over baseline of patient satisfaction scores</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong>&lt;br&gt;(10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td>care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1 [I-12.1]: Documentation of increased number of visits.</strong>&lt;br&gt;Baseline: 0 visits in DY2&lt;br&gt;Goal: 1,000 completed visits.&lt;br&gt;Data Source: EHR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment <em>(maximum amount):</em>&lt;br&gt;$2,619,020</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: <em>(add incentive payments amounts from each milestone):</em>&lt;br&gt;$7,132,488</td>
<td>Year 3 Estimated Milestone Bundle Amount: $7,781,161</td>
<td>Year 4 Estimated Milestone Bundle Amount: $7,803,781</td>
<td>Year 5 Estimated Milestone Bundle Amount: $6,446,602</td>
<td></td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD <em>(add milestone bundle amounts over Years 2-5):</em> $29,164,032</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Project Option 1.1.2- Expand existing primary care capacity: Expand Capacity of existing Health Centers

Unique RHP Project ID: 133355104.1.3 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

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

Volume Statistics - FY2012

<table>
<thead>
<tr>
<th>Hospital admissions- 35,343</th>
<th>Self-Pay- 62.6%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births (babies delivered)- 6,643</td>
<td>Medicaid and CHIP- 23.4%</td>
</tr>
<tr>
<td>Emergency visits- 173,263</td>
<td>Medicare- 8.6%</td>
</tr>
<tr>
<td>Outpatient clinic visits- 1,054,770</td>
<td>Other Funding- 3.6%</td>
</tr>
<tr>
<td></td>
<td>Commercial Insurance- 1.8%</td>
</tr>
</tbody>
</table>

Patient Demographics

- Hispanic- 57.4%
- African American- 26.3%
- Caucasian- 9.2%
- Asian- 4.8%
- Other- 2.2%
- American Indian- 0.2%

Intervention(s):
This project will expand the existing capacity of primary care by adding full time equivalent primary care providers to meet the adult primary care demand surrounding the Health Centers. Harris Health System plans to add additional providers and support staff to maximize the use of our existing clinical space, thereby increasing appointment availability.

Need for the project:
Currently, Harris Health System Health Centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health Center providers are currently 95% empaneled.

Target Population:
All current and potential medical home patients within the system with may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

Category 1 or 2 expected patient benefits:
Our goal is to increase primary care clinic completed visits by additional primary care providers to 2,500 completed visits in DY3, 15,000 in DY4, and 30,000 in DY5. The project seeks to increase primary care completed visits by an additional 47,500 visits by DY5.

Category 3 outcomes:
IT-6.2: Our goal is to increase the Access survey dimension score by 0.5% above baseline in DY4 and 1% in DY5 (Press Ganey).
Project Option 1.1.2- Expand existing primary care capacity: Expand Capacity of existing Health Centers

**Unique RHP Project ID:** 133355104.1.3 / Pass 1  
**Performing Provider Name/TPI:** Harris Health System / 133355104

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

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

**Goal(s) and Relationship to Regional Goal(s):**  
The goals of this project are to:  
- Increase capacity for primary care through the addition of primary care providers in the Medical Home setting.  

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

This project meets the following Region 3 goals:  
- Increase access to primary and specialty services with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.  

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

**Challenges:**  
The general primary care capacity has been a challenge for the Harris Health System. The providers are approximately 95% empaneled and thus unable to accept new patients at most Health Centers. The clinics currently have existing clinical space that’s being underutilized. To address these challenges, we propose to add additional physicians to maximize the use of clinical space for patient care. The additional providers will increase the access to new patients and improve appointment availability.

**5-Year Expected Outcome for Provider and Patients:**  
Over the course of the 5-Year Waiver, Harris Health System expects to realize:  
- Increased capacity to offer Medical Homes primarily for adults by adding providers in the existing primary care setting.
Over time, overall patient satisfaction for Access at targeted health centers will increase.

**Starting Point/Baseline:**
The baseline for Harris Health System FY2012 is 228,070 primary care visits.
The baseline for Ease of scheduling appointments as measured by Press Ganey for the period October 2011 through September 2012 Patient Satisfaction Survey year is 71.3%.

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

**Project Components:**
   a) Expand primary care clinic space
   b) Expand primary care clinic hours
   c) Expand primary care clinic staffing
Expansion of primary care clinic space is not necessary at this time because the clinic has underutilized exam rooms. The visit demand is for regular operating hours.

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

**Unique community need identification number the project addresses:**
This project addresses the following community needs according to the community needs assessment:
   • CN.1- Inadequate access to primary care
   • CN.11- High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including: Cancer, Diabetes, Obesity, Cardiovascular disease, Asthma, AIDS/HIV

**How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:**
The addition of primary care providers in the existing Health Centers complements the proposed projects to establish same day access. As patients are treated in same day access
clinics, patients in need of a Medical Home will be routed to Harris Health System Health Centers.

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

OD-6 Patient Satisfaction
- IT-6.2: Percent improvement over baseline of patient satisfaction scores

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

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

**Relationship to other Projects:**

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

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

**Project Valuation:** This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in Harris County. The value of the project is based on the expansion of services in Harris Health System’s NCQA certified medical home clinics, substantially increasing our capacity to provide primary care services, including laboratory testing, imaging, and other ancillary services, along with prescription medications and timely referrals for specialty care and other needed services within the Harris Health System network. The increase in provider staffing throughout the existing medical home network can ultimately result in a total of an additional 47,500 completed visits in DY3-5, including the coordination of chronic disease education and management for patients needing those services. In addition, the availability of incremental primary care appointments will result...
in fewer emergency room visits for public and private hospitals located in the service area. Early
detection, treatment and education regarding wellness and prevention will also help to prevent
future downstream inpatient admissions.
### Harris Health System 133355104

**EXPAND EXISTING PRIMARY CARE CAPACITY: EXPAND CAPACITY OF EXISTING HEALTH CENTERS**

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>133355104.3.3</th>
<th>IT-6.2</th>
<th>Other: Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
</table>

|-------|-------------------------|--------------------------|--------------------------|--------------------------|

**Milestone 1 [P-X]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- **Metric 1 [P-X.1]:** Planning documentation
  - Goal: Produce a comprehensive implementation plan for expansion of providers at Health Center
  - Data Source: Project plan

  Milestone 1 Estimated Incentive Payment *(maximum amount)*: $14,167,705

**Milestone 2 [P-5]:** Hire additional primary care providers and staff

- Metric 1 [P-5.1]: Documentation of increased number of providers and staff.
  - Baseline: 0 providers and staff hired in DY2.
  - Goal: Hire 4 providers
  - Data Source: Contract documentation

Milestone 2 Estimated Incentive Payment *(maximum amount)*: $7,728,103

**Milestone 3 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

- Metric 1 [I-12.1]: Documentation of increased number of visits.
  - Goal: 2,500 completed visits
  - Data Source: EHR

Milestone 3 Estimated Incentive Payment *(maximum amount)*: $7,728,102

**Milestone 4 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

- Metric 1 [I-12.1]: Documentation of increased number of visits.
  - Baseline: 3,000 completed visits in DY3
  - Goal: 15,000 completed visits
  - Data Source: EHR

Milestone 4 Estimated Incentive Payment: $7,750,568

**Milestone 5 [P-5]:** Hire additional primary care providers and staff

- Metric 1 [P-5.1]: Documentation of increased number of providers and staff.
  - Baseline: 0 providers and staff hired in DY2.
  - Goal: Hire 1 provider, for total of 14 providers
  - Data Source: Contract documentation

Milestone 5 Estimated Incentive Payment *(maximum amount)*: $7,750,568

**Milestone 6 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

- Metric 1 [I-12.1]: Documentation of increased number of visits.
  - Goal: 15,000 completed visits in DY4
  - Data Source: EHR

Milestone 6 Estimated Incentive Payment *(maximum amount)*: $6,402,643

**Milestone 7 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

- Metric 1 [I-12.1]: Documentation of increased number of visits.
  - Baseline: 30,000 completed visits in DY5 for a total of 47,500 visits in DY3-5.
  - Data Source: EHR

Milestone 7 Estimated Incentive Payment: $6,402,643

---

Regional Healthcare Partnership Plan

Region 3

178
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>IT-6.2</th>
<th>Other: Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $14,167,705</td>
<td>Year 3 Estimated Milestone Bundle Amount: $15,456,205</td>
<td>Year 4 Estimated Milestone Bundle Amount: $15,501,136</td>
</tr>
<tr>
<td>Year 5 Estimated Milestone Bundle Amount: $12,805,286</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5): $57,930,332*
Project Option 1.1.1- Establish more primary care clinics: West and Northwest 1 Area Health Centers

Unique RHP Project ID: 133355104.1.4 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

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

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

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

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

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

Category 1 or 2 expected patient benefits:
Our goal is to increase primary care clinic completed visits to 1,500 completed visits in DY3, 8,000 in DY4, and 15,500 in DY5. These two clinics will have seen 25,000 total completed visits by DY5 (DY3-DY5).

Category 3 outcomes:
IT-1.10: Our goal is to decrease the percentage of patients with poorly controlled diabetes by 0.5% below baseline in DY4 and 1% in DY5.
Project Option 1.1.1- Establish more primary care clinics: West and Northwest 1 Area Health Centers

Unique RHP Project ID: 133355104.1.4 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104

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

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

Goal(s) and Relationship to Regional Goal(s):
The goals of this project are to:

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

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

This project meets the following Region 3 goals:

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

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

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

5-Year Expected Outcome for Provider and Patients:
Over the course of the 5-Year Waiver, Harris Health System expects to realize:
- Increased adult-focused primary care capacity through the addition of the West and Northwest 1 Area Health Centers.

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

Rationale:
Currently, Harris Health System Health Centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health Center providers are currently 95% empaneled. Moreover, physicians in Harris Health System Health Centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at Health Centers. These Health Centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For the Northwest and El Franco Lee Health Centers combined, there were 852 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. The Northwest and El Franco Lee Health Centers received 145 Ask My Nurse in-basket messages per month for patients that needed same day appointments that could not be scheduled by the Patient Appointment Center. Within the Harris Health System, 28% of all requests received in September 2012 for Family Practice appointments that could not be scheduled were for patients living in zip codes served by the El Franco Lee and Northwest Health Centers. These numbers, however, do not capture the full volume of unmet demand due to the fact that some patients may be likely to hang up when placed on hold and some patients who needed care likely did not attempt to obtain an appointment based on previous difficulties obtaining appointments. Based on 2012 data of incoming patient calls to the Patient Appointment Center over 34,000 unduplicated patients were unable to get an appointment.

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

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

Milestones & (Metrics):
- Process Milestones and Metrics- P-1 (P-1.1); P-5 (P-5.1); P-X (P-X.1); P-X2 (P-X2.1)
- Improvement Milestones and Metrics- I-12 (I-12.1)
Unique community need identification number the project addresses:
This project addresses the following community needs according to the community needs assessment:
- CN.1- Inadequate access to primary care
- CN.8- High rates of inappropriate emergency department utilization

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
The addition of Health Centers to the existing platform of Health Centers that offer Medical Homes complements the proposed establishment of same day clinics. As patients are treated in same day access sites, patients in need of care management available at Medical Home sites will be routed to Harris Health System Health Centers.

Related Category 3 Outcome Measure(s):
OD-1 Primary Care and Chronic Disease Management
- IT-1.10- Diabetes care: HbA1c poor control (>9.0%)

Reasons/rationale for selecting the outcome measure(s):
The West and Northwest 1 Area Health Centers will increase capacity for primary care visits within the Harris Health System, which will enhance access and improve the patient’s experience in obtaining services. The West and Northwest 1 Area Health Centers will offer additional access, affording patients the opportunity to seek care. The improved appointment availability to care will allow diabetes patients enhanced access to better manage diabetes. The West and Northwest 1 Area Health Centers will establish the baseline of percentage of poorly controlled diabetes (>9.0%) in DY3. The Health Center will increase appointment availability for both new and return patients. The enhanced access to care will result in improved hemoglobin A1c (<9.0%).

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

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

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

**Project Valuation:** This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinics’ capacity to provide a medical home for primary care services, including laboratory point-of-care testing, some imaging, other ancillary services and prescription medications along with timely referrals for specialty care and other needed services within the Harris Health System network. We expect to achieve optimum capacity and productivity by the end of DY5, ultimately resulting in 15,500 completed visits per year. We will coordinate of chronic disease education and management for patients needing those services. In addition, the availability of timely primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>133355104.3.4</th>
<th>IT-1.10</th>
<th>Diabetes care: HbA1c poor control (&gt;9.0%)</th>
</tr>
</thead>
</table>

### Establish more primary care clinics: West and Northwest 1 Area Health Centers

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Milestone 1** [P-X]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans | **Milestone 2** [P-1]: Establish additional primary care clinics  
**Metric 1** [P-1.1]: Number of additional clinics or expanded hours or space  
Baseline: 0 additional clinics in target area in DY2  
Goal: Establish one additional clinics for the West and Northwest 1 area  
Data Source: New primary care schedule | **Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services  
**Metric 1** [I-12.1]: Documentation of increased number of visits  
Baseline: 1,500 completed visits in DY3  
Goal: 8,000 completed visits  
Data Source: EHR | **Milestone 7** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services  
**Metric 1** [I-12.1]: Documentation of increased number of visits  
Baseline: 8,000 completed visits in DY4  
Goal: 15,500 completed visits for a total of 25,000 visits in DY3-5  
Data Source: EHR |
| **Metric 1** [P-X.1]: Planning documentation  
Goal: Produce a comprehensive implementation plan for the establishment of West and Northwest 1 Area Health Centers  
Data Source: Project plan | **Milestone 2** Estimated Incentive Payment (maximum amount): $2,557,336 | **Milestone 5** Estimated Incentive Payment (maximum amount): $3,847,154 | **Milestone 7** Estimated Incentive Payment (maximum amount): $6,356,168 |
| **Milestone 1** Estimated Incentive Payment (maximum amount): $7,032,432 | **Milestone 3** [P-5]: Hire additional primary care providers and staff  
**Metric 1** [P-5.1]: Documentation of increased number of providers and staff  
Baseline: 0 providers and staff hired in DY2  
Goal: Hire 9 provider FTE’s  
Data Source: Contract documentation | **Milestone 6** [P-5]: Hire additional primary care providers and staff  
**Metric 1** [P-5.1]: Documentation of increased number of providers and staff  
Baseline: 0 providers and staff hired in DY2  
Goal: Hire 5 additional provider FTE’s for a total of 14 provider FTE’s  
Data Source: Contract documentation | **Milestone 6** Estimated Incentive Payment: $3,847,154 |
<p>| <strong>Milestone 3</strong> Estimated Incentive Payment: $2,557,335 | <strong>Milestone 4</strong> Estimated Incentive Payment (maximum amount): $3,847,154 | <strong>Milestone 6</strong> Estimated Incentive Payment: $3,847,154 | <strong>Milestone 7</strong> Estimated Incentive Payment (maximum amount): $6,356,168 |</p>
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Goal: 1,500 completed visits. Data Source: EHR. Milestone 4 Estimated Incentive Payment (maximum amount): $2,557,335</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $7,032,432</td>
<td>Year 3 Estimated Milestone Bundle Amount: $7,672,006</td>
<td>Year 4 Estimated Milestone Bundle Amount: $7,694,308</td>
<td>Year 5 Estimated Milestone Bundle Amount: $6,356,168</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $28,754,914</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Project Option 1.1.1- Establish more primary care clinics: Northwest 2 Area Health Center

**Unique RHP Project ID:** 133355104.1.5 / Pass 1
**Performing Provider Name/TPI:** Harris Health System / 133355104

**Project Summary:**

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

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

**Intervention(s):**
Harris Health System proposes to expand the capacity of primary care by adding the Northwest 2 Area Health Center to the complement of existing health centers to establish Medical Homes primarily for the adult population.

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

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

**Category 1 or 2 expected patient benefits:**
Our goals are to increase primary care clinic completed visits to 500 completed visits in DY3, 3,000 in DY4, and 6,500 in DY5. By DY5, this clinic will have seen 10,000 completed visits (DY3-DY5).

**Category 3 outcomes:**
IT-1.10: Our goal is to decrease the percentage of patients with poorly controlled diabetes by 0.5% below baseline in DY4 and 1% in DY5.
Project Option 1.1.1- Establish more primary care clinics: Northwest 2 Area Health Center

Unique RHP Project ID: 133355104.1.5 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104

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

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

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

Goal(s) and Relationship to Regional Goal(s):
The goals of this project are to:
- Increase capacity for primary care through the addition of a primary care Health Centers that will serve as a Medical Home primarily for the adult population.

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

This project meets the following Region 3 goals:
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

The Northwest 2 clinic will increase access to primary care in a high-demand area of underserved individuals while ensuring that patients have access to care in the appropriate setting. Harris County residents will be treated, and care discounted, according to Harris Health’s sliding fee scale, with determination of eligibility for financial assistance.
Challenges:
General primary care capacity has been a challenge for the Harris Health System. The Northwest 2 Area Health Centers will provide access to a Medical Home for patients. A significant challenge for the Harris Health System has been adequate capacity to offer Medical Homes for patients who do not have a primary care provider. The providers are approximately 95% empaneled and thus unable to accept new patients at most Health Centers. To address these challenges, we propose to add this Health Center to increase access to new patients and improve appointment availability.

5-Year Expected Outcome for Provider and Patients:
Over the course of the 5-Year Waiver, Harris Health System expects to realize:

- Increased adult-focused primary care capacity through the addition of the Northwest 2 Area Health Center.

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

Rationale:
Currently, Harris Health System Health Centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health Center providers are currently 95% empaneled. Moreover, physicians in Harris Health System Health Centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at Health Centers. These Health Centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For the Northwest and El Franco Lee Health Centers combined, there were 852 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. The Northwest and El Franco Lee Health Centers received 145 Ask My Nurse in-basket messages per month for patients that needed same day appointments that could not be scheduled by the Patient Appointment Center. Within the Harris Health System, 28% of all requests received in September 2012 for Family Practice appointments that could not be scheduled were for patients living in zip codes served by the El Franco Lee and Northwest Health Centers. These numbers, however, do not capture the full volume of unmet demand due to the fact that some patients may be likely to hang up when placed on hold and some patients who needed care likely did not attempt to obtain an appointment based on previous difficulties obtaining appointments. Based on 2012 data of incoming patient calls to the Patient Appointment Center over 34,000 unduplicated patients living near the El Franco Lee and Northwest Health Centers were unable to get an appointment.

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

Project Components:
Not Applicable / The project option 1.1.1 does not have components
Milestones & (Metrics):
- Process Milestones and Metrics- P-1 (P-1.1); P-5 (P-5.1); P-X (P-X.1); P-X2 (P-X2.1)
- Improvement Milestones and Metrics- I-12 (I-12.1)

Unique community need identification number the project addresses:
This project addresses the following community needs according to the community needs assessment:
- CN.1- Inadequate access to primary care
- CN.8- High rates of inappropriate emergency department utilization

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

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

Related Category 3 Outcome Measure(s):
OD-1 Primary Care and Chronic Disease Management
- IT-1.10- Diabetes care: HbA1c poor control (>9.0%)

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

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

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

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

**Project Valuation:** This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic’s capacity to provide a medical home for primary care services, including laboratory point-of-care testing, some imaging, other ancillary services and prescription medications along with timely referrals for specialty care and other needed services within the Harris Health System network. We expect to achieve optimum capacity and productivity by the end of DY5, ultimately resulting in 6,500 completed visits per year. We will coordinate chronic disease education and management for patients needing those services. In addition, the availability of timely primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>133355104.3.5</th>
<th>IT-1.10</th>
<th>Diabetes care: HbA1c poor control (&gt;9.0%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-X]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-X.1]: Planning documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Produce a comprehensive implementation plan for the establishment of Northwest 2 Area Health Center</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Project plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 1 Estimated Incentive Payment (maximum amount):</strong></td>
<td>$8,370,608</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-1]: Establish additional primary care clinics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-1.1]: Number of additional clinics or expanded hours or space</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline: 0 additional clinics in target area in DY2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Establish one additional clinic for the Northwest 2 area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: New primary care schedule</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 2 Estimated Incentive Payment (maximum amount):</strong></td>
<td>$3,043,961</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3</strong> [P-5]: Hire additional primary care providers and staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-5.1]: Documentation of increased number of providers and staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline: 0 providers and staff hired in DY2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Hire 1 provider FTE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Contract documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3 Estimated Incentive Payment:</strong></td>
<td>$3,043,962</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 4</strong> [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [I-12.1]: Documentation of increased number of visits.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline: 500 completed visits in DY3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: 3,000 completed visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5 Estimated Incentive Payment (maximum amount):</strong></td>
<td>$4,579,215</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 6</strong> [P-5]: Hire additional primary care providers and staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-5.1]: Documentation of increased number of providers and staff.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline: 0 providers and staff hired in DY2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Hire 3 additional provider FTE’s for a total of 4 provider FTE’s</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Contract documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 6 Estimated Incentive Payment:</strong></td>
<td>$4,579,215</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 7</strong> [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [I-12.1]: Documentation of increased number of visits.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline: 3,000 completed visits in DY4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: 6,500 completed visits for a total of 10,000 visits in DY3-5.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 7 Estimated Incentive Payment (maximum amount):</strong></td>
<td>$7,565,660</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2 (10/1/2012 – 9/30/2013)**

**Year 3 (10/1/2013 – 9/30/2014)**

**Year 4 (10/1/2014 – 9/30/2015)**

**Year 5 (10/1/2015 – 9/30/2016)**
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>N/A</th>
<th>establishing more primary care clinics: northwest 2 area health center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harris Health System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>133355104.3.5</td>
<td>IT-1.10</td>
<td>Diabetes care: HbA1c poor control (&gt;9.0%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>patients seeking services.</td>
<td>Metric 1 [I-12.1]: Documentation of increased number of visits. Goal: 500 completed visits Data Source: EHR</td>
<td>Milestone 4 Estimated Incentive Payment (maximum amount): $3,043,961</td>
<td></td>
</tr>
</tbody>
</table>

Year 2 Estimated Milestone Bundle Amount: $8,370,608
Year 3 Estimated Milestone Bundle Amount: $9,131,884
Year 4 Estimated Milestone Bundle Amount: $9,158,430
Year 5 Estimated Milestone Bundle Amount: $7,565,660

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $34,226,582
Project Option 1.1.1- Establish more primary care clinics: Southwest, Medical Center, and Northeast Same Day Access Clinics

**Unique RHP Project ID:** 133355104.1.6 / Pass 1  
**Performing Provider Name/TPI:** Harris Health System / 133355104

**Project Summary:**

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

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

**Intervention(s):**
Harris Health System proposes to expand the capacity of primary care by establishing adult-focused primary care clinics that offer same day visits during extended hours to meet demand that saturated existing Harris Health System health centers cannot meet.

**Need for the project:**
Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. From March 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care.

**Target Population:**
All current and potential patients seeking primary care services within the system may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%), specifically those residing in or around the following zip codes: 77031, 77026, 77028, 77030, 77025.

**Category 1 or 2 expected patient benefits:**
Our goals are to see 3,000 completed visits in DY3, 21,000 in DY4, and 31,500 in DY5, for a total of 55,500 visits from DY3-DY5.

**Category 3 outcomes:**
IT 6.2- Other: Percent improvement over baseline of Patient Satisfaction scores: 0.5% improvement in DY4 and 1% improvement in DY5.
Project Option 1.1.1- Establish more primary care clinics: Southwest, Medical Center, and Northeast Same Day Access Clinics

Unique RHP Project ID: 133355104.1.6 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104

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

The same day access clinics will be located in or around the following zip codes to meet the adult primary care demand surrounding the El Franco Lee and People’s Health Centers, LBJ General Hospital, and Ben Taub General Hospital: 77031, 77026, 77028, 77030, and 77025. The three clinics will be approximately 1,500-3,000 square feet each of leased space. The Facilities and Planning department at the Harris Health System has confirmed that such lease space is available in or around the target zip codes. Harris Health System plans to add new providers and staff to operate the clinic for extended evening hours and weekend hours, in addition to regular weekday hours, based on demand. Point of Care lab testing will be available. If patients are in need of imaging or pharmacy services, they will be referred to the nearest facility that provides those services.

Goals and Relationship to Regional Goals:
The goals of this project are to:
- Increase capacity for same day primary care through establishment of more accessible care locations across Harris County
- Increase access to same day primary care during extended hours and weekends

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

This project meets the following Region 3 goals:
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

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

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

**5-Year Expected Outcome for Provider and Patients:**
Over the course of the 5-Year Waiver, Harris Health System expects to realize:
- Increased adult-focused primary care capacity through same day care clinics for primary care treatable conditions

**Starting Point/Baseline:**
For performance purposes, the baseline will be set at 0 visits since these are new clinics that currently are not operational.

**Rationale:**
Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health System health centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For the El Franco Lee and People’s health centers, there were 908 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. Within the Harris Health System, 30% of all requests received in September 2012 for Family Practice appointments that could not be scheduled were for patients living in zip codes served by the El Franco Lee and People’s health centers. El Franco Lee and People’s Health Centers received 145 Ask My Nurse requests per month for patients that needed same day appointments that could not be scheduled by the Patient Appointment Center. These numbers, however, do not capture the full volume of unmet demand due to the fact that some calls were dropped as patients were placed on hold and some patients who needed care did not attempt to obtain an appointment based on previous difficulties obtaining same day appointments. Based on 2012 data of incoming patient calls to the Patient Appointment Center, 4,627 unduplicated patients living near the El Franco Lee and People’s Health Centers were unable to get an appointment.

Ben Taub and LBJ General Hospital sees a high volume of patients that would be more appropriately treated in the same day access clinic setting. The addition of same day access clinics in close proximity will result in increased access to same day care for primary care treatable conditions, a more cost effective and appropriate setting than emergency centers and a more accessible setting than saturated Medical Home health centers.
Project Components:
Not Applicable / The project option 1.1.1 do not have components

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

Unique community need identification number the project addresses:
This project addresses the following community needs according to the community needs assessment:
- CN.1- Inadequate access to primary care
- CN.8- High rates of inappropriate emergency department utilization
- CN.2- Inadequate access to specialty care

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

Related Category 3 Outcome Measure(s):
OD-6 Patient Satisfaction
IT 6.2- Other: Percent improvement over baseline of Patient Satisfaction scores: 0.5% improvement in DY4 and 1% improvement in DY5.

Reasons/rationale for selecting the outcome measure(s):
The same day access clinics will increase capacity for primary care visits within the Harris Health System, which will enhance access and improve the patient’s experience in obtaining services. Patient satisfaction scores have been historically poor for health centers regarding timely access to care. The same day access clinics will offer an efficient venue that offers same day visits, affording patients the opportunity to seek care in a setting that is appropriate for the level of care they need and more cost effective than other alternatives. IT-6.2 was specifically chosen as Harris Health will be using Press-Ganey (approved by HHSC) as the source for survey metrics and results. The survey chosen measures all aspects of a patient visit, and thus will give Harris Health System a comprehensive indication of how we are performing.

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

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

**Project Valuation:** This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic’s capacity to provide primary care services, including laboratory point-of-care testing, along with timely referrals for specialty care, imaging and other needed services within the Harris Health System network. We expect to achieve optimum capacity and productivity by the end of DY5, ultimately resulting in 55,500 completed visits per year. We will refer new patients with chronic disease management needs to one of the NCQA certified medical home clinics that are operated by Harris Health. In addition, the availability of same day primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.
<table>
<thead>
<tr>
<th>Milestone 1 [P-X]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1 [P-X.1]: Planning documentation</strong></td>
</tr>
<tr>
<td>Goal: Produce a comprehensive implementation plan for the establishment of same day access clinic</td>
</tr>
<tr>
<td>Data Source: Project plan</td>
</tr>
<tr>
<td><strong>Milestone 1 Estimated Incentive Payment (maximum amount): $14,173,677</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 2 [P-1]: Establish additional primary care clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space</strong></td>
</tr>
<tr>
<td>Baseline: 0 same day access clinics in target area in DY2</td>
</tr>
<tr>
<td>Goal: Establish three same day access clinic</td>
</tr>
<tr>
<td>Data Source: New primary care schedules</td>
</tr>
<tr>
<td><strong>Milestone 2 Estimated Incentive Payment (maximum amount): $5,154,240</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 3 [P-5]: Hire additional primary care providers and staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1 [P-5.1]: Documentation of increased number of providers and staff.</strong></td>
</tr>
<tr>
<td>Baseline: 0 providers and staff hired in DY2</td>
</tr>
<tr>
<td>Goal: Hire 11 Provider FTEs (MD and/or MLP) Data Source: Contract documentation</td>
</tr>
<tr>
<td><strong>Milestone 3 Estimated Incentive Payment: $5,154,240</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 4 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1 [I-12.1]: Documentation of increased number of visits.</strong></td>
</tr>
<tr>
<td>Goal: 21,000 completed visits in DY4 (aggregate from all three clinics). Data Source: EHR</td>
</tr>
<tr>
<td><strong>Milestone 4 Estimated Incentive Payment (maximum amount): $5,507,670</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 5 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1 [I-12.1]: Documentation of increased number of visits.</strong></td>
</tr>
<tr>
<td>Goal: 31,500 completed visits in DY5, for a total of 55,500 completed visits in DY3-5 (aggregate from all three clinics). Data Source: EHR</td>
</tr>
<tr>
<td><strong>Milestone 5 Estimated Incentive Payment (maximum amount): $15,507,670</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 6 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1 [I-12.1]: Documentation of increased number of visits.</strong></td>
</tr>
<tr>
<td>Goal: 31,500 completed visits in DY5, for a total of 55,500 completed visits in DY3-5 (aggregate from all three clinics). Data Source: EHR</td>
</tr>
<tr>
<td><strong>Milestone 6 Estimated Incentive Payment (maximum amount): $12,810,684</strong></td>
</tr>
<tr>
<td>Related Category 3</td>
</tr>
<tr>
<td>--------------------</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $14,173,677</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $57,954,751
Project Option 1.9.3- “Other” project option: Implement other evidence-based project to expand specialty care capacity: Pre-consult evaluations to facilitate efficient specialty care.

Unique Project ID #: 133355104.1.7 / Pass 1  
Performing Provider/TPI: Harris Health System/133355104

**Project Summary:**

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

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions- 35,343</td>
<td>Self-Pay- 62.6%</td>
<td>Hispanic- 57.4%</td>
</tr>
<tr>
<td>Births (babies delivered)-</td>
<td>Medicaid and CHIP-</td>
<td>African American- 26.3%</td>
</tr>
<tr>
<td>6,643</td>
<td>23.4%</td>
<td>Caucasian- 9.2%</td>
</tr>
<tr>
<td>Emergency visits- 173,263</td>
<td>Medicare- 8.6%</td>
<td>Asian- 4.8%</td>
</tr>
<tr>
<td>Outpatient visits- 1,054,770</td>
<td>Other Funding- 3.6%</td>
<td>Other- 2.4%</td>
</tr>
<tr>
<td></td>
<td>Commercial Insurance- 1.8%</td>
<td></td>
</tr>
</tbody>
</table>

**Intervention(s):**
This project will address the inefficiency of specialty clinics (focusing primarily on diabetes and rheumatology clinics) by making possible ordering best practices diagnostic algorithmic workups and eliminating the current practice of sequential ordering of individual tests which is resources and time wasteful as well as error prone. This will insure optimal testing prior to specialty consult and appropriate referral. The project will streamline the referral process and increase the productivity of both PCPs and specialists.

**Need for the project:**
It takes about 6 months to get a consult in the Harris Health rheumatology clinic. Similar backlogs exist for other consult services. Most patients arrive for their consult with inadequate work ups or do not have the condition in question. This number is about 50% of total number of consults in rheumatology service. The inadequacy of consultation process for diabetic patients is also illustrated by the fact that over 43% of African Americans are not aware of their diabetic kidney disease until one week prior to kidney failure and need for dialysis. We have identified several causes of the inefficiency that could be addressed by restructuring the diagnostic process.

**Target Population:**
All patients within the system may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%), with a focus on those referred to diabetes and rheumatologic clinics.

**Category 1 or 2 expected patient benefits:**
Our goal is to decrease the rate of rejected primary care provider-initiated referrals to specialty care for rheumatology and endocrine clinics. We hope to decrease the rate of rejected/inappropriate referrals from PCPs to these clinics by 7%, 15%, and 20% for rheumatology clinic (DY3-DY5). For endocrine clinic, we plan to decrease this rate by 5%, 7%, and 10% (DY3-DY5). Based on these percentages, the potential patient impact is about 1,040 total patients by DY5, which translates into increased access for appropriate referrals.

**Category 3 outcomes:**
IT-1.1- Our goal is to decrease wait time from specialty referral to specialty clinic visit for relevant specialties (endocrine and rheumatology) by 5%, 10%, and 15% from baseline in DY3-DY5 respectively.
IT-1.14- Diabetes care: Microalbumin/Nephropathy- Goals for DY4 and DY5 to be determined.
IT-1.10-Diabetes care: HbA1c poor control (>9.0%) 233 NQF 0059- Our goal is to decrease below the baseline we plan to establish in DY3. Goals are 2% below baseline in DY4 and 3% below in DY5.
Project Option 1.9.3- “Other” project option: Implement other evidence-based project to expand specialty care capacity: Pre-consult evaluations to facilitate efficient specialty care.

**Unique Project ID #:** 133355104.1.7 / Pass 1  
**Performing Provider/TPI:** Harris Health System/133355104

**Project Description:**
*Harris Health System proposes a project that will address the opportunity for increased efficiency in the referral processes to specialty clinics. This project will focus on developing algorithms to address diabetes mellitus and rheumatology clinic.*

ACOs and medical homes are designed to ensure continuity of care and facilitation of efficient use of specialty consultations. This project will address two limitations of these models: first, the limited ability of providers to keep current with the ever more complex diagnostic technologies and, second, the wasteful procedures necessary to navigate the labyrinth of operational inefficiencies. Our approach is based on the fact that pathologists through the laboratories produce around 70% of all data in medical records and are specifically trained in diagnostic medicine. The goal is to use these resources in an efficient consultative manner to improve selection and preparation of patients for specialty consultations across the entire spectrum of the Harris Health System.

Harris Health System serves Harris County, which is the 3rd largest County in the US. The system has a $1.2 billion budget, 7500 FTEs and operates 3 hospitals and an ambulatory network with over 1,000,000 visits annually, 10,000 consults / month and 10,000 calls for appointments per week. The Harris Health clinics systematically experience shortage of clinic availability for specialty consults. For example, it usually takes about 6 months to get a rheumatologist consult at the Lyndon B. Johnson rheumatology clinic. Similar backlogs exist for other consult services. This delays the initiation of the necessary treatment, negatively affects the patient’s health, and produces dissatisfaction and frustration. Our analysis and discussions with clinicians revealed several causes of the backlogs that could be addressed with little capital investments by restructuring of the diagnostic process.

The current system requires physician’s justification of every test on every patient. It is unreasonable to expect any practicing clinician to be familiar with the best diagnostic practices across the entire spectrum of diseases. EMRs make patient information accessible, but offer little help in either directing workups of complex conditions or managing arcane and wasteful processes of test ordering and reporting.

This project will focus primarily on diabetes mellitus (DM)/pre-diabetes and rheumatologic conditions. Our plan is to make it possible for providers to efficiently order the most appropriate best practices algorithm driven laboratory workups for particular patients. The pre-consult algorithms will be developed by pathologists in consultation with both primary care and specialist providers. They will be executed in the laboratory and reported with a concise explanation of what was done and the meaning of the results. The interpretation of algorithms will be done by pathologists during the developmental phase. As best practices become clarified, nurses or other personnel will likely be able to interpret some algorithms. However, others that require review of the medical record and a physician’s judgment will continue to be done by pathologists. As the expertise and infrastructure develop, we will consider piloting similar approaches to several other specialties (Hematology and coagulation, Hepatology, etc.) that are not a part of the milestones and goals formulated for this project. The project will begin with
pre-consult evaluations for rheumatology and endocrinology and progress to the entire spectrum of diagnostic medicine.

This evaluation will be used by referral service (specially trained referral nurses interacting with clinical pathologists) to determine the need for consult, for triaging the consult requests depending on urgency and clinical condition. The approach will also ensure that the patients come to the specialty consult with the entire set of tests needed to make the diagnosis, thus eliminating/minimizing the need for additional visits. As a result, introduction of this approach will free up significant number of specialist consult spots, increase the productivity of the specialist and “unclog” the referral service by increasing the throughput without employing additional providers and major capital investments. For consult requests that are denied, referring primary care physicians will receive a detailed explanation of the reasons and alternatives to consider.

The project’s final outcome will be expansion of specialty care by increasing productivity and streamlining the work of existing PCPs and specialists. It combines elements of expanding specialty care and improved access to specialty care with emphasis on improving effectiveness of existing personnel and facilities by inserting diagnostic algorithms and pathologists’ pre-consults into the preparation for specialty consults. This project is intended to make better use of existing specialty services without major capital investments.

In regard to diabetes significant emphasis will be placed on certain ethnic populations (Hispanics, African Americans and Asian/ Vietnamese) considering the disproportionally high prevalence of this condition and early complications in these ethnic groups. There is vast literature supporting this notion for African Americans. Disturbingly, the incidence of end stage renal disease (ESRD) due largely to diabetes continues to mount in young African Americans (J Am Soc Nephrology 18, 1038-45, 2007). African Americans make up only 13% of the US population, yet constitute 32% of patients with ESRD. The risk for developing ESRD is at least three-fold higher in African Americans. Very troublesome that according to this study over 43% of African Americans with kidney failure were not aware of kidney disease until one week before their kidneys failed entirely and they required dialysis. Hispanic Americans also have a high prevalence of diabetes. Among all diabetics, Hispanic patients are six times more likely to develop chronic kidney disease and to advance to end-stage disease. Experience at Harris Health points also towards increased prevalence among Vietnamese. About 50% of patients served by Harris Health are Hispanic, 26% - African Americans and 5% - Asian (mainly Vietnamese). That provides an idea of involved costs and possible savings if diabetes early evaluation program (DEEP) and complications early evaluation program (CEEP) (see the goals section below) are successfully implemented.

Goals and Relationship to Regional Goals:
Project goals:
• Develop an algorithm for diabetes early evaluation program (DEEP) and for diabetes complications early evaluation program (CEEP) and implement programs in clinics. The CEEP will focus primarily on kidney complications (nephropathy); it will also require blood pressure measurements, retinal and foot examinations by PCPs as a part of the algorithm to satisfy the fast track of the referral protocol
• Introduce the algorithm-based work-ups and pre-consult evaluations for major rheumatologic conditions (total 5).
• Develop laboratory and referral center workflows and train technologists and nurses to execute them.
• Develop knowledge based systems to facilitate efficient preparation of reports that contain both the test results and an explanation of the implications for each patient.
• Work with information technology (IT) department to implement ordering and reporting of the algorithm-based work-ups.
• Assess the value of algorithmic and consultative diagnostic workups for clinicians and use their input to further improve of the effectiveness processes.

This project meets the following regional goals:
• Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
• Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

All the regional institutions providing diagnostic and consulting services experience the same problems with shortness of slots for clinic visits and especially for consults. Thus, this project will provide a demonstration of means to improve efficiency of healthcare and patient satisfaction in the region.

Challenges:
We have found that both PCP and specialist physicians immediately understand value of this project and are anxious to participate in developing and using algorithms. The challenges lie within laboratories that must develop new workflows, with pathologists who must learn a new discipline and with information systems who must build complex new functionality.

Our approach is to use manual or pilot scale methods to introduce and refine processes. A medical technologist will manage samples in the laboratory, order tests of an algorithm, and collate results for pathologist interpretation. The interpretations will be facilitated using database that we have used for years in assisting with complex interpretations in hematopathology (http://pathology.uth.tmc.edu/faculty/pages/nguyen-nghia/decision.html). We will work with information systems continuously to determine when a process is sufficiently stable to warrant full development and then plan and execute such development. Education of nurses and medical technologists as well as pathologists is essential.

5-year expected outcome for Performing Provider and patients:
• Increase the capacity of clinics and consulting services by reducing the number of patient visits required to solve diagnostic problems.
• Reduce the need for emergency room visits and hospitalizations that result from delayed or inaccurate diagnoses in the clinics.
• Increase (with little capital investments) the throughput and productivity of the specialists consulting services by “unclogging” the Consulting System through eliminating unnecessary consults and minimizing the number of excessive visits due to incomplete pre-consult testing.
• Improve quality of care by decreasing the waiting time and eliminating unnecessary repeated visits due to incomplete pre-consult testing; enhancing patients’ satisfaction.
• Make possible (or facilitate) providing quality care for expected significant influx of patients due to implementation of ACA and the 1115 Waver without major increase of numbers of providers and capital investment.

Starting Point/Baseline:
The Harris Health System has a busy centralized referral department staffed by nurses (10) and clerks. We began working with this department early in the process of developing algorithms in order obtain an illustration of the effectiveness of this approach. The focus was on systemic lupus erythematosus (SLE) referrals. The test run demonstrated that implementation of the algorithms could help greatly with workflow and result in reduction of the backlog for the rheumatology clinic by about half (from nearly 6 to about 2 1/2 months).

In review of 80 cases in the test run of the algorithm for SLE in late May, June and early July, it became clear that this might provide significant benefits if properly applied. For example, of the 80 cases, 4 were graded as ‘URGENT, 30 were ‘APPROVED for routine consultation and 49 were ‘DENIED. Some of the denials were returned to complete the necessary laboratory work. Six patients had positive TSH or hepatitis panels, which warranted an endocrinology or gastrointestinal rather than rheumatology consultations. It has been demonstrated that proper managing of the proposed program could substantially reduce the number of inappropriate consultations and allow patients with more severe disease to obtain early rheumatology appointments. Only 15 of the 80 patients had a urinalysis, sedimentation rate and CRP performed. Many others did not have CBCs or appropriate autoantibody measurements. Under the proposed plan, the pathologist reviewing the consult will order the indicated tests using the already collected sample. This will save time and money for the patients, nurses and physicians who would otherwise have to pass the information to several facilities to get the testing done.

Some of the cases appear to be more complex, requiring review of the medical records and physician’s judgment. Adding specialized laboratory medicine physician’s judgment at a critical point in the work-up would be far more effective and efficient than available alternatives. This is an example where specialized expertise in laboratory work-ups of patients with suspected SLE would be preferable instead of trying to educate primary care providers across the system in areas of technology they will only use occasionally. Pathologists will collate the results into a single report with a narrative explanation of what was done and the meaning of the results. Intention is to make this understandable and educational to both providers and patients.

Rationale:
A significant number of patients scheduled for specialty consults often do not have the condition in question. These patients get scheduled for consult due to PCP overload, insufficient or inappropriate laboratory testing and cumbersome delivery of laboratory results. A rough estimate shows that this number is about 50% of total number of consults in rheumatology service. PCPs need assistance in choosing the optimal tests to make the best diagnostic decisions and eliminate unnecessary consults to triage the remaining consults based on the urgency of the situation and need for specialist involvement.

Extended laboratory diagnostic work-ups commonly start after the initial visit to a specialist. Second/third visits are typically necessary for the data to be reviewed by a specialist and management decisions to be made and implemented. This process takes up a significant
number of consult clinic openings that could be used more effectively by other patients in line and delays the implementation of treatment.

It is not uncommon that by the time laboratory testing is completed, it becomes clear that the patient did not have the condition in question. At this point, the patient may have already undergone up to 3 unnecessary specialty clinic visits. This often leads to repetition of the entire process until there is a correct diagnosis.

Laboratories produce 70% of all data in typical medical records, and placing professional expertise in the laboratory makes it possible for PCP’s to order algorithmic workups and laboratory consultations. Clinical pathologists would be responsible for reviewing data and providing actionable reports for clinicians. Best practice algorithms will be made conveniently available to all providers and executed efficiently within the laboratory saving costs, time, and frustrations of unnecessary or inappropriate tests and nonproductive clinic visits.

Medical errors are significant contributors to cost and undesirable outcomes in medicine. Significant errors are reported to occur in as much as 15% of cases. (Diagnostic Errors in Acute Care, 2010) Much attention has been focused on therapeutic errors such as drug dose; however, diagnostic errors are responsible for twice as many adverse events as medication errors. (Creating a Value-Driven Laboratory:Opportunities in the New Marketplace, 2012) 44% of the diagnostic errors were failure to order, report, process or follow up on results of laboratory tests or x-rays. In addition, 70% of diagnostic errors have been attributed to data gathering, data synthesis, or clinical knowledge (Creating a Value-Driven Laboratory:Opportunities in the New Marketplace, 2012). Introduction of evidence based work-ups and use of locally developed best practices algorithms together with the expertise of specialists in diagnostic laboratory medicine will reduce errors and improve performance in each of these areas.

**Project Components:** Not applicable.

**Milestones and Metrics:** P-X1, P-X1.1; P-X2, P-X2.1, P-2, P-2.1; P-5, P-5.1; P-6, P-6.1; I-X1, I-X1.1; I-X2, I-X2.1; I-26, I-26.1

**Unique community need identification numbers the project addresses:**
- CN.2 Inadequate access to specialty care

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This is an entirely new initiative for Harris Health System. Some institutions such as Partners in Boston, use pre-consult algorithms and others like Vanderbilt, use pathologist laboratory consultations; but, we do not know of any other institution that has initiated a project that combines these elements together. In developing the programs for diabetes (DEEP and CEEP), we will use the experience of others that have successfully accomplished elsewhere. The National Kidney Foundation uses an algorithm of clinical and laboratory data in order to identify people with diabetes and/or kidney disease before they become clinically symptomatic, namely, the Kidney Early Evaluation Program (KEEP.) Another program implemented by the University of Miami screened employees of the Polk County School Board. In only two years, it produced savings in total healthcare costs of $456.44 / per covered live / per year for an ROI of 1:1.73. The savings from case finding are expected to increase further as the patients continue with chronic
care. We will work with specialist and primary care physicians in Harris Health to adapt these and other best practices to our environment and our goals.

**Related Category 3 Outcome Measures:**
- OD-1: Primary Care and Chronic Disease Management
- IT-1.1: Third Next Available Appointment (non-standalone)
- IT-1.14: Diabetes care: Microalbumin/Nephropathy- NQF 0062 (non-standalone)
- IT-1.10: Diabetes care: HbA1c poor control (>9.0%)233-NQF 0059

**Reasons/rationale for selecting the outcome measures:**
In an effort to increase efficiencies in the primary care setting, this project is proposing algorithms for diabetes and rheumatological conditions. We decided to measure three outcomes that are overall goals of the project. In an effort to increase efficiencies, we have chosen IT-1.1 as we aim to decrease the amount of time a patient must wait between specialty clinic referral and actual visit. Diabetes is a focus for our region, and we plan to implement an algorithm that will focus on diabetes screening. We decided that IT-1.14 and IT-1.10 are important in the success of this particular part of the project.

**Relationship to other projects:** The increase of primary care and specialty care will naturally result in additional ambulatory care encounters for our region patient base. The ambulatory initiatives cover items such as laboratory, PT/OT, social work, etc. and are a necessity of our patients to ensure a comprehensive treatment for access as well as cost avoidance. The Region 3 initiative grid in the addendum reflects all ambulatory operations initiatives.

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

**Project Valuation:** This project will focus primarily on diabetes mellitus (DM)/pre-diabetes and rheumatologic conditions, making it possible for providers to efficiently order the most appropriate best practices algorithm driven laboratory workups for particular patients. The value of the project is based on cost savings and efficiencies through (1) increasing the capacity of clinics and consulting services by reducing the number of patient visits required to solve diagnostic problems, (2) reducing the need for emergency room visits and hospitalizations that result from delayed or inaccurate diagnoses in the clinics, (3) increasing the throughput and productivity of the specialists consulting services by eliminating unnecessary consults, and (4) improving quality of care by decreasing the waiting time and eliminating unnecessary repeated visits due to incomplete pre-consult testing; thus enhancing patients’ satisfaction. In addition, these improvements will facilitate providing quality care for expected significant influx of patients due to implementation of Affordable Care Act (ACA) and the 1115 Waiver without a major increase in the number of providers and capital investment. We hope to decrease the percentage of inappropriate referrals to endocrine and rheumatology, with a potential to impact up to 1,040 patients by DY5.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1** [P-6]: Develop and implement standardized referral and work-up guidelines

**Metric 1** [P-6.1]: Referral and work-up guidelines.

- Goal: Develop algorithms for work-up, risk assessment, referral triaging for diabetes and rheumatologic conditions. Pilot the developed protocols algorithms for diabetes and (2) rheumatologic conditions.
- Data Source: Referral and work-up policies and procedures documents.

Milestone 1 Estimated Incentive Payment: $ 1,241,582

**Milestone 2** [P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties

**Metric 1** [P-2.1]: Training of staff and providers on referral guidelines, process and technology.

- Baseline: will be established
- Goal: Pilot to include 5% of

Milestone 2 Estimated Incentive Payment: $1,693,125

**Milestone 6** [I-X1]: Increase % of providers using algorithms for the diagnosis and management of diabetes conditions

**Metric 1** [I-X1.1]: % increase of physicians using established algorithms for diabetes conditions.

- Goal: 20% of total providers using algorithms
- Data Source: Referral management system, EHR

Milestone 6 Estimated Incentive Payment: $1,693,125

**Milestone 7** [I-X2]: Increase % of providers using algorithms for rheumatologic conditions.

**Metric 1** [I-X2.1]: % increase of physicians using established algorithms for rheumatologic conditions.

- Goal: 30% increase above baseline
- Data Source: Referral management system, EHR

Milestone 7 Estimated Incentive Payment: $ 1,693,125

**Milestone 10** [I-X1]: Increase % of providers using algorithms for the diagnosis and management of diabetes conditions

**Metric 1** [I-X1.1]: % increase of physicians using established algorithms for diabetes conditions.

- Goal: 30% of total providers using algorithms
- Data Source: Referral management system, EHR

Milestone 10 Estimated Incentive Payment: $ 1,698,047

**Milestone 11** [I-X2]: Increase % of providers using algorithms for rheumatologic conditions.

**Metric 1** [I-X2.1]: % increase of physicians using established algorithms for rheumatologic conditions.

- Goal: 40% of total providers using algorithms
- Data Source: Referral management system, EHR

Milestone 11 Estimated Incentive Payment: $ 1,698,047

**Milestone 14** [I-X1]: Increase % of providers using algorithms for the diagnosis and management of diabetes conditions

**Metric 1** [I-X1.1]: % increase of physicians using established algorithms for diabetes conditions.

- Goal: 40% of total providers using algorithms
- Data Source: Referral management system, EHR

Milestone 14 Estimated Incentive Payment: $1,402,734

**Milestone 15** [I-X2]: Increase % of providers using algorithms for rheumatologic conditions.

**Metric 1** [I-X2.1]: % increase of physicians using established algorithms for rheumatologic conditions.

- Goal: 50% of total providers using algorithms
- Data Source: Referral management system, EHR

Milestone 15 Estimated Incentive Payment: $1,402,734
**“Other” Project Option: Implement Other Evidence-Based Project to Expand Specialty Care Capacity in an Innovative Manner Not Described in the Project Options: Pre-Consult Evaluations to Facilitate Efficient Specialty Care**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Harris Health System</th>
<th>133355104</th>
</tr>
</thead>
<tbody>
<tr>
<td>133355104.3.7</td>
<td>IT-1.1</td>
<td>N/A</td>
</tr>
<tr>
<td>133355104.3.8</td>
<td>IT-1.14</td>
<td></td>
</tr>
<tr>
<td>133355104.3.9</td>
<td>IT-1.10</td>
<td></td>
</tr>
</tbody>
</table>

- **Year 2 (10/1/2012 – 9/30/2013)**
  - **Milestone 2**: Estimated Incentive Payment: $1,241,582
  - **Metric 1 [P-X1.1]**: Establish baselines for rate of inappropriate or rejected referrals in diabetes conditions.
    - Data Source: EMR; Log of staff trained and training curriculum
  - **Milestone 8 [I-26]**: Reduce the rate of inappropriate or rejected referrals
    - **Metric 1 [I-26.1]**: Rate of Rejected/Accepted Primary Care Provider-Initiated Referrals to Specialty Care. This rate will be calculated on a quarterly basis and reported for most recent quarter.
      - Goal: 5% decrease of rejected referrals from baseline for diabetes clinics
    - Data Source: eReferral or other referrals system
    - Milestone 8 Estimated Incentive Payment: $1,693,125

- **Year 3 (10/1/2013 – 9/30/2014)**
  - **Milestone 3 [P-X1]**: Establish baselines for rate of inappropriate or rejected referrals in diabetes conditions.
  - **Milestone 9 [I-26]**: Reduce the rate of inappropriate or rejected referrals
    - **Metric 1 [I-26.1]**: Rate of Rejected/Accepted Primary Care Provider-Initiated Referrals to Specialty Care. This rate will be calculated on a quarterly basis and reported for most recent quarter.
      - Goal: 7% decrease of rejected referrals from baseline for diabetes clinics
    - Data Source: EMR
    - **Milestone 12 [I-26]**: Reduce the rate of inappropriate or rejected referrals
      - **Metric 1 [I-26.1]**: Rate of Rejected/Accepted Primary Care Provider-Initiated Referrals to Specialty Care. This rate will be calculated on a quarterly basis and reported for most recent quarter.
        - Goal: 7% decrease of rejected referrals from baseline for diabetes clinics
    - Data Source: eReferral or other referrals system
    - Milestone 12 Estimated Incentive Payment: $1,698,047

- **Year 4 (10/1/2014 – 9/30/2015)**
  - **Milestone 4 [P-X2]**: Establish baselines for rate of inappropriate or rejected referrals in rheumatologic conditions.
  - **Milestone 13 [I-26]**: Reduce the rate of inappropriate or rejected referrals
    - **Metric 1 [I-26.1]**: Rate of Rejected/Accepted Primary Care Provider-Initiated Referrals to Specialty Care. This rate will be calculated on a quarterly basis and reported for most recent quarter.
      - Goal: 15% decrease of rejected referrals from baseline for rheumatologic clinics
    - Data Source: eReferral or other referrals system
    - **Milestone 16 [I-26]**: Reduce the rate of inappropriate or rejected referrals
      - **Metric 1 [I-26.1]**: Rate of Rejected/Accepted Primary Care Provider-Initiated Referrals to Specialty Care. This rate will be calculated on a quarterly basis and reported for most recent quarter.
        - Goal: 10% decrease of rejected referrals from baseline for rheumatologic clinics
    - Data Source: eReferral or other referrals system
    - Milestone 16 Estimated Incentive Payment: $1,402,734

- **Year 5 (10/1/2015 – 9/30/2016)**
  - **Milestone 5 [I-26]**: Reduce the rate of inappropriate or rejected referrals
    - **Metric 1 [I-26.1]**: Rate of Rejected/Accepted Primary Care Provider-Initiated Referrals to Specialty Care. This rate will be calculated on a quarterly basis and reported for most recent quarter.
      - Goal: 20% decrease of rejected referrals from baseline for rheumatologic clinics
    - Data Source: eReferral or other referrals system
    - **Milestone 17 [I-26]**: Reduce the rate of inappropriate or rejected referrals
      - **Metric 1 [I-26.1]**: Rate of Rejected/Accepted Primary Care Provider-Initiated Referrals to Specialty Care. This rate will be calculated on a quarterly basis and reported for most recent quarter.
        - Goal: 20% decrease of rejected referrals from baseline for rheumatologic clinics
    - Data Source: eReferral or other referrals system
    - Milestone 17 Estimated Incentive Payment: $1,452,369

---

*Regional Healthcare Partnership Plan*

133355104.1.7 1.9.3 N/A

*Harris Health System*

133355104

*Third Next Available Appointment (non-standalone)*

Diabetes care: Microalbumin/Nephropathy - NQF 0062 (non-standalone)

Diabetes care: HbA1c poor control (>9.0%) - 233-NQF 0059
"**OTHER** PROJECT OPTION: IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO EXPAND SPECIALTY CARE CAPACITY IN AN INNOVATIVE MANNER NOT DESCRIBED IN THE PROJECT OPTIONS: PRE-CONSULT EVALUATIONS TO FACILITATE EFFICIENT SPECIALTY CARE"

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Harris Health System</th>
<th>133355104</th>
</tr>
</thead>
<tbody>
<tr>
<td>133355104.3.7</td>
<td>IT-1.1</td>
<td>Third Next Available Appointment (non-standalone)</td>
<td>133355104</td>
</tr>
<tr>
<td>133355104.3.8</td>
<td>IT-1.14</td>
<td>Diabetes care: Microalbumin/Nephropathy- NQF 0062(non-standalone)</td>
<td>133355104</td>
</tr>
<tr>
<td>133355104.3.9</td>
<td>IT-1.10</td>
<td>Diabetes care: HbA1c poor control (&gt;9.0%)233-NQF 0059</td>
<td>133355104</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: TBD</td>
<td>Data Source: eReferral or other referrals system</td>
<td>Data Source: eReferral or other referrals system</td>
<td>Data Source: eReferral or other referrals system</td>
</tr>
<tr>
<td>Goal: Establish % of inappropriate or rejected referrals</td>
<td>Milestone 9 Estimated Incentive Payment: $ 1,693,125</td>
<td>Milestone 13 Estimated Incentive Payment: $ 1,698,047</td>
<td>Milestone 17 Estimated Incentive Payment: $ 1,402,734</td>
</tr>
<tr>
<td>Data Source: EMR</td>
<td>Milestone 4 Estimated Incentive Payment: $ 1,241,582</td>
<td>Milestone 5 Estimated Incentive Payment: $ 1,241,582</td>
<td>Milestone 9 Estimated Incentive Payment: $ 1,693,125</td>
</tr>
</tbody>
</table>

**Milestone 5 [P-5]:** Provide reports on wait time from receipt of referral to actual referral appointment

**Metric 1 [P-5.1]:** Generate and provide reports on average referral process time and/or time to appointment

Goal: Establish baseline for average referral process time and/or time to appointment for diabetes and rheumatologic conditions

Data Source: EHR, referral management system, administrative records

Milestone 5 Estimated Incentive Payment: $ 1,241,582
```
<table>
<thead>
<tr>
<th>133355104.1.7</th>
<th>1.9.3</th>
<th>N/A</th>
<th>“OTHER” PROJECT OPTION: IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO EXPAND SPECIALTY CARE CAPACITY IN AN INNOVATIVE MANNER NOT DESCRIBED IN THE PROJECT OPTIONS: PRE-CONSULT EVALUATIONS TO FACILITATE EFFICIENT SPECIALTY CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harris Health System</td>
<td>133355104</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Related Category 3 Outcome Measure(s):**
- 133355104.3.7
- 133355104.3.8
- 133355104.3.9

**Outcome Measure(s):**
- IT-1.1
- IT-1.10

**Third Next Available Appointment (non-standalone)**
- Diabetes care: Microalbumin/Nephropathy- NQF 0062(non-standalone)
- Diabetes care: HbA1c poor control (>9.0%)233-NQF 0059

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $ 6,207,912</td>
<td>Year 3 Estimated Milestone Bundle Amount: $ 6,772,498</td>
<td>Year 4 Estimated Milestone Bundle Amount: $ 6,792,186</td>
<td>Year 5 Estimated Milestone Bundle Amount: $ 5,610,936</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5): $ 25,383,532*
```
Project Option- 1.1.2 Expand Existing Primary Care Capacity: Referrals to FQHCs

**Unique RHP Project ID:** 133355104.1.8 / Pass 1  
**Performing Provider Name/TPI:** Harris Health System / 133355104

**Project Summary:**

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

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

**Intervention(s):**
Harris Health System proposes to develop a seamless referral process by which Harris Health can refer primary care patients to FQHCs, as necessary. The additional providers will result in an additional 22,500 visits by DY5.

**Need for the project:**
Currently, FQHCs throughout Harris County serve high demand, underserved areas. However, many have underutilized clinic space that can accommodate additional providers and expand existing primary care capacity.

**Target Population:**
All current and potential patients seeking primary care services within the system and at FQHCs may benefit from this project (Overall Payor Mix: Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

**Category 1 or 2 expected patient benefits:**
Our goal is to increase primary care clinic completed visits in the FQHC’s by 5,500 visits in DY 3, 7,000 visits in DY 4 and 10,000 visits in DY 5 for a total of 22,500 completed at the end of DY 5.

**Category 3 outcomes:**
IT-6.2: Our goal is to increase patient satisfaction scores overall by 0.5% above baseline in DY4 and increase overall patient satisfaction scores by 1% above baseline in DY 5
Project Option- 1.1.2 Expand Existing Primary Care Capacity: Referrals to FQHCs

**Unique RHP Project ID:** 133355104.1.8 / Pass 1  
**Performing Provider Name/TPI:** Harris Health System / 133355104

**Project Description:**
*Harris Health System proposes to expand the capacity of primary care by referring Harris Health patients to local Federally Qualified Health Centers in order to meet the demand that saturated existing Harris Health System health centers cannot meet.*

Currently, FQHCs throughout Harris County serve high demand, underserved areas. However, many have underutilized clinic space that can accommodate additional providers and expand existing primary care capacity. Thus, Harris Health System, as performing provider, proposes to collaborate with FQHCs to refer Harris Health patients to targeted FQHCs by developing a seamless referral process by which Harris Health can refer primary care patients to FQHCs, as necessary. This will result in an additional 22,500 completed visits by DY5. Each FQHC differs in size, location, and target population, but many are located proximate to a Harris Health System health center, allowing for easy referrals and convenient locations for many patients. Partner FQHCs include: Central Care Community Health Center, El Centro de Corazon; Good Neighbor Healthcare Center; Healthcare for the Homeless – Houston; Houston Area Community Services (HACS); HOPE Clinic; Independence Heights Community Health Center; Legacy Community Health Services; Pasadena Health Center; Spring Branch Community Health Center; and Vecino Health Centers (Denver Harbor Family Clinic and Airline Children’s Clinic). Target zip codes are listed below according to FQHC partner. Healthcare for the Homeless-Houston serves all zip codes.

<table>
<thead>
<tr>
<th>Legacy- Montrose</th>
<th>Legacy- Baytown</th>
<th>Good Neighbor / HACS / Independence Heights / Spring Branch</th>
<th>Pasadena</th>
</tr>
</thead>
<tbody>
<tr>
<td>77001</td>
<td>77520</td>
<td>77018 77092</td>
<td>77034</td>
</tr>
<tr>
<td>77002</td>
<td>77521</td>
<td>77024 77098</td>
<td>77058</td>
</tr>
<tr>
<td>77003</td>
<td>77522</td>
<td>77043 77265</td>
<td>77059</td>
</tr>
<tr>
<td>77006</td>
<td>77530</td>
<td>77046 77090</td>
<td>77062</td>
</tr>
<tr>
<td>77019</td>
<td>77532</td>
<td>77055 77022</td>
<td>77089</td>
</tr>
<tr>
<td>77098</td>
<td>77562</td>
<td>77079 77076</td>
<td>77209</td>
</tr>
<tr>
<td>Legacy- Southwest / Hope Clinic</td>
<td></td>
<td>Good Neighbor / HACS / Independence Heights / Spring Branch</td>
<td>Pasadena</td>
</tr>
<tr>
<td>77027</td>
<td>77071</td>
<td>77037 77088</td>
<td>77052</td>
</tr>
<tr>
<td>77036</td>
<td>77074</td>
<td>77008 77014</td>
<td>77055</td>
</tr>
<tr>
<td>77056</td>
<td>77081</td>
<td>77038 77086</td>
<td>77056</td>
</tr>
<tr>
<td>77057</td>
<td>77096</td>
<td>77040 77041</td>
<td>77057</td>
</tr>
<tr>
<td>77063</td>
<td>77099</td>
<td>77064 77065</td>
<td>77536</td>
</tr>
<tr>
<td>77031</td>
<td>77072</td>
<td>77066 77067</td>
<td>77546</td>
</tr>
<tr>
<td>77082</td>
<td>77077</td>
<td>77068 77069</td>
<td>77547</td>
</tr>
<tr>
<td>77083</td>
<td>77070</td>
<td>77095 77571 &amp; 77598</td>
<td></td>
</tr>
<tr>
<td>Legacy- 5th Ward / Denver Harbor</td>
<td>El Centro de Corazon</td>
<td>Central Care</td>
<td></td>
</tr>
<tr>
<td>77013</td>
<td>77011</td>
<td>77004</td>
<td></td>
</tr>
<tr>
<td>77015</td>
<td>77012</td>
<td>77033</td>
<td></td>
</tr>
<tr>
<td>77016</td>
<td>77017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>77020</td>
<td>77023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>77026</td>
<td>77029</td>
<td></td>
<td></td>
</tr>
<tr>
<td>77028</td>
<td>77061</td>
<td></td>
<td></td>
</tr>
<tr>
<td>77044</td>
<td>77075</td>
<td></td>
<td></td>
</tr>
<tr>
<td>77049</td>
<td>77087</td>
<td></td>
<td></td>
</tr>
<tr>
<td>77078</td>
<td>77078</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Goal(s) and Relationship to Regional Goal(s):
The goals of this project are to:

- Increase capacity for primary care visits by referring Harris Health System patients to existing local FQHC’s.
  Expanding the capacity of primary care through referrals to FQHCs will better accommodate the needs of the community and allow patients to receive the right care at the right time in the right setting.

This project meets the following Region 3 goals:

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

This project will increase access to primary care in high-demand areas of underserved individuals while ensuring that patients have access to care in the appropriate setting, regardless of their ability to pay.

Challenges:

General primary care capacity has been a challenge for the Harris Health System. A significant challenge for the Harris Health System has been adequate capacity to offer Medical Homes for patients who do not have a primary care provider. The Referrals to FQHCs project will expand capacity for primary care and connect patients to care in a timely fashion that would otherwise not be possible.

There will be an additional challenge to develop a referral system for patients who seek an appointment at the Harris Health System for whom the demand cannot be met, as well as a referral system for patients who seek care for primary care treatable conditions in the Harris Health Emergency Centers. A seamless system will be developed so that patients are referred to the FQHCs for establishment of a Medical Home.

The nature of the partnerships required by this project adds complexity to successful implementation. While the project requires additional contract procurement for the subcontracting of services, the Legal and Compliance departments at Harris Health System have significant experience in this area and Harris Health currently subcontracts for a number of services. Monitoring provider and staff recruitment activities, provider performance, and adherence to standardized referral guidelines will also be a challenge. The development of standardized processes and procedures relating to the aforementioned areas of concern will be a focus of the planning period in DY2.

5-Year Expected Outcome for Provider and Patients:
Over the course of the 5-Year Waiver, Harris Health System expects to realize:

- Increased adult-focused primary care capacity (22,500 additional visits) through a smooth referral process to the FQHC.

In DY 5, Harris Health hopes to have 22,500 completed visits through the referral of Harris Health System patients.

Starting Point/Baseline:
For performance purposes, the baseline will be set at 0 additional visits at targeted FQHCs.
Rationale:
Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health System health centers carry a panel of 2,250 patients, plus an additional 500 patients for each midlevel provider who works with them to manage their patient panel. These panel sizes are higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. This volume, however, does not capture the full volume of unmet demand. Without access to primary care, patients are more likely to seek care in Emergency Centers, which is a higher cost and not convenient for patients. Care is better coordinated in a Medical Home, leading to better management of chronic disease, improved patient satisfaction, and better outcomes. The referral of Harris Health patients to local FQHCs will result in increased access to primary care.

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

This project will not directly address components a) or b). At targeted FQHCs, there is significant space that is currently underutilized. Moreover, expanded hours are already offered at select FQHCs. Thus, this project aims to maximize opportunities for Harris Health patients to access care at local FQHC’s. Even though this project will not directly add more staff FTEs, there will be increased capacity through referrals to FQHCs that have available space and capacity.

Milestones & (Metrics):
- Process Milestones and Metrics-P-X (P-X.1); P-X2 (P-X2.1)
- Improvement Milestones and Metrics- I-12 (I-12.1)

Unique community need identification number the project addresses:
This project addresses the following community needs according to the community needs assessment:
- CN.1- Inadequate access to primary care

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
While Harris Health System has collaborated with local FQHCs in various ways, a project aimed at increasing access for Harris Health patients and developing a formalized referral process for primary care has not been explored. The project will promote true collaboration through a mutual, patient-centered goal that will refer patients to a primary care location that is appropriate and convenient by leveraging the ability of the Harris Health System to secure and reimburse local FQHC’s to offer expanded access to support the primary care needs of Harris Health patients. This project to refer patients to the FQHCs complements the project to establish same day access clinics (133355104.1.1; 133355104.1.2 133355104.1.6).

No federal funds, including HRSA funds, will be comingled with DSRIP funds. However, FQHCs may seek out non-federal/private funding to support the planning phase for their internal expansion efforts.
**Related Category 3 Outcome Measure(s):**  
OD-6 Patient Satisfaction  
- IT-6.2- Percent improvement over baseline of patient satisfaction scores (standalone)

We will measure improvement in overall satisfaction scores over time at FQHCs of the Access dimension using Press Ganey’s Medical Practice Survey.

**Reasons/rationale for selecting the outcome measure(s):**  
From March 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. According to survey results for the last 12 months as reported by Press Ganey, the patient satisfaction score for all Harris Health primary care Medical Home health centers regarding standard Access to Care survey questions is 76.8. Without access to primary care, patients are more likely to seek care in Emergency Centers, where they will wait longer and their care is not coordinated. If patients are satisfied with the care they receive at their Medical Home, they are more likely to seek care promptly when needed in the appropriate setting, more adherent to provider recommendations for disease management, and more satisfied with the care they receive. We have selected IT-6.2 because it is an effective tool for assessing improvement in access to care and for the targeted development of process improvement needs. Harris Health System wishes to ensure a positive patient experience internally and in the area at partner FQHC facilities.

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

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

**Project Valuation:**  
This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved/uninsured population in Harris County. It will expand capacity for primary care medical homes and connect patients to care in a timely fashion that might not otherwise be possible. A referral system will be developed for patients who seek an appointment at the Harris Health System for whom the demand cannot be met in a timely manner, as well as for patients who seek care for primary care treatable conditions in the Harris Health Emergency Centers. The value of the project is based on the incremental capacity to provide primary care services at the community FQHCs, along with timely referrals for specialty care and other needed services within the Harris Health System network. Within this framework we project to increase access by a total of 22,500 additional visits at the end of DY 5. In addition, the availability of incremental primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>EXPAND PRIMARY CARE CAPACITY - REFERENCES TO FQHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>13335104.3.10</td>
<td>IT-6.2 Other: Percent improvement over baseline of patient satisfaction scores</td>
</tr>
</tbody>
</table>

### Milestone 1 [P-X]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- **Metric 1 [P-X.1]: Planning documentation**
  - Goal: Produce a comprehensive implementation plan for referrals to FQHCs
  - Data Source: Project plan

- **Milestone 1 Estimated Incentive Payment (maximum amount):** $4,893,329

### Milestone 2 [P-X2]: Establish baseline number of scheduled visits by additional primary care providers

- **Metric 1 [P-X2.1]: Documentation of scheduled visits by additional primary care providers**
  - Baseline: 0 completed visits in DY2
  - Goal: 5,500 scheduled visits (through referrals)
  - Data Source: EHR

- **Milestone 2 Estimated Incentive Payment (maximum amount):** $5,338,359

### Milestone 3 [P-X3]: Establish baseline number of scheduled visits by additional primary care providers

- **Metric 1 [P-X3.1]: Documentation of scheduled visits by additional primary care providers**
  - Baseline: 0 completed visits in DY2
  - Goal: 5,500 scheduled visits (through referrals)
  - Data Source: EHR

- **Milestone 3 Estimated Incentive Payment (maximum amount):** $5,338,359

### Milestone 4 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

- **Metric 1 [I-12.1]: Documentation of increased number of visits.**
  - Baseline: Established in DY3
  - Goal: 7,000 scheduled visits (through referrals)
  - Data Source: EHR

- **Milestone 4 Estimated Incentive Payment (maximum amount):** $5,353,877

### Milestone 5 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

- **Metric 1 [I-12.1]: Documentation of increased number of visits.**
  - Baseline: Established in DY3
  - Goal: 10,000 scheduled visits (through referrals)
  - Data Source: EHR

- **Milestone 5 Estimated Incentive Payment (maximum amount):** $4,422,768

### Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $4,893,329

### Year 3 Estimated Milestone Bundle Amount: $5,338,359

### Year 4 Estimated Milestone Bundle Amount: $5,353,877

### Year 5 Estimated Milestone Bundle Amount: $4,422,768

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $20,008,333
Project Option 1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Expansion of Pediatric Behavioral Health Services

**Unique RHP Project Identification Number:** 133355104.1.9 / Pass 1  
**Performing Provider Name/TPI:** Harris Health System/TPI 133355104

**Project Summary:**

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

**Volume Statistics - FY2012**

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

**Intervention(s):**
This project will address the shortage of pediatric and adolescent behavioral health services by implementing and expanding these services across nine facilities within the system. We propose to expand psychiatry by adding 3.7 FTE’s of psychiatry and 7.6 FTE’s of behavioral therapy.

**Need for the project:**
Currently, Harris Health System offers pediatric and adolescent behavioral health services at five of its facilities with a total of 1.3 psychiatry FTEs and 3.4 behavioral therapy FTEs.

**Target Population:**
This project specifically targets patients in the following zip codes and surrounding areas of Harris County seeking behavioral health services: 77074, 77012, 77099, 77547, 77039, 77520, 77504, 77084, and 77070. Data from FY2012 shows that 60% of all pediatric visits in Harris Health System were funded.

**Category 1 or 2 expected patient benefits:**
Our DY3 goal is to increase the number of visits from baseline by 25%. In DY4, we aim to increase by 70% from DY3 completed visits and in DY5 we aim to increase by 40% from DY4 completed visits. By DY5 we estimate an additional 37,319 cumulative visits.

**Category 3 outcomes:**
IT-6.2: Our goal is to increase patient satisfaction scores (patients are getting timely care, appointments, and information) by 5% in DY4 and 1% in DY5. We selected a low increase because many existing sites have higher than average patient satisfaction scores within the Harris
Health System. Pediatric sites start in the highest percentile ranking benchmarked to other national facilities.
Project Option 1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Expansion of Pediatric Behavioral Health Services

**Unique RHP Project Identification Number:** 133355104.1.9 / Pass 1  
**Performing Provider Name/TPI:** Harris Health System/TPI 133355104

**Project Description:**  
*Harris Health System will address Project Option 1.12.2 related to the shortage of pediatric and adolescent behavioral health services by implementing and expanding these services across eight facilities within the system.*

Currently, Harris Health System offers pediatric and adolescent behavioral health services at five of its facilities. The scope of this project is to increase access to these services in areas of high need in the community, specifically to serve the following zip codes and surrounding areas of Harris County: 77074, 77012, 77099, 77547, 77039, 77520, 77504, 77084, and 77070.

**Goals and Regional Goals:**

**Project Goals:**
- Increase psychiatry and behavioral therapy staffing at existing locations within Harris Health System. We propose to expand psychiatry to 5.0 FTE’s (currently 1.3 FTE’s) and expand behavioral therapy to 11 FTE’s (currently 3.4 FTE’s). We will also hire 5.0 additional FTE’s of support staff. The additional workforce will increase access to behavioral health services for the pediatric population of Harris County.
- Increase capacity in underserved areas.
- Treat children and adolescents in appropriate outpatient setting for potential decrease in need for inpatient behavioral health services.

**Regional goals addressed with the project:**
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition.
  - This project addresses this regional goal by focusing on areas with high numbers of low-income families who may otherwise not have adequate access to appropriate levels of outpatient behavioral health services for children and adolescents.
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction
  - This project addresses the growing need for behavioral health services for the state of Texas. Expansion of services will help address this need at an earlier stage in life, which is vital for a successful outcome.

**Challenges:**
There is an inadequate number of behavioral health providers in the region and across the state of Texas, which includes a shortage of child psychiatrists. Harris Health System faces an even greater challenge, as much of our patient population served is primarily Spanish speaking, making it more difficult to find behavioral health professionals who can communicate effectively...
in the patient’s language of choice. Harris Health System plans to actively recruit, hire, and train behavioral health providers to address these challenges in DY2.

- Inpatient behavioral health services have been reduced in Harris County. One of the area’s major inpatient psychiatric hospitals was closed due to loss of its Medicaid/Medicare certification. The lack of inpatient beds for pediatric and adolescent behavioral health patients is a challenge for Harris Health System, the region, and Texas as a whole. Behavioral health needs may lead to school failure, behavioral conflicts, and substance abuse; if left untreated, these problems may become more difficult and costly to treat. Expanding pediatric and adolescent behavioral health services through projects as proposed, has the potential to help decrease the need for inpatient behavioral health beds by addressing issues at earlier stages in life.

**5-Year Expected Outcome for Performing Provider and Patients:**
By addressing the challenges for the region and Harris Health System as performing provider, we expect to achieve the overarching goal of increasing availability to pediatric and adolescent behavioral health services to underserved areas of Harris County. In reaching these goals, we expect to maintain high levels of patient satisfaction as evident by our survey scores reported throughout the latter demonstration years of the waiver.

**Starting Point/Baseline:**
Volume: In FY13 YTD, there were approximately 5,877 pediatric psychiatry and behavioral health therapy visits. This will serve as DY2 volume baseline. FTEs: In FY12, there were 0.9 psychiatry FTEs and 2.4 behavioral therapy FTEs. These will serve as baselines for the expected workforce beginning in DY2.

Currently, Harris Health System offers pediatric and adolescent behavioral health services at five of its facilities. We will be expanding services within these five facilities and will also add services at four additional sites.

**Rationale:**
Studies have shown that at least 1 in 5 children and adolescents have a mental health disorder in the United States, with 1 in 10 children suffering a disorder so severe that it disrupts daily living (SAMHSA’S National Mental Health Information Center, 2003). They include depression, anxiety, and conduct disorder and are often a direct link to what is happening in their home. Additionally, children and youth from low income households are at an increased risk for mental health problems (U.S. Department of Health and Human Services) and Latino children are less likely to receive mental health services than children from other ethnic groups. In Texas 65% of Latino children live in low-income homes.

Mental health is an essential component in a child’s development. Children need to be healthy in order to learn, grow and become productive adults. Although the critical link between a children’s mental health and positive development, opportunities to improve outcomes for these children continue to be missed. Without treatment, the consequences can be severe. School dropouts, substance abuse, entanglement with the juvenile justice system, or even suicide are some of the costs of no treatment. The monetary cost of children’s mental health disorders in the U.S. is $247 billion annually (National Research Council). Building a strong comprehensive system to support children’s mental health initiatives is crucial. Key components include promoting early childhood mental health, policy development, integrating mental health into
primary care settings, providing culturally and linguistically competent services, and collaborating with stakeholders in mental health, schools, families, and the community.

Current challenges for adequate delivery of pediatric behavioral health delivery include funding, insurance limitations, limited providers, language and cultural barriers between providers and patients, growing need, social stigma, and a lack of parental and early intervention services. Currently, Texas ranks 49th in the nation in behavioral health expenditures per capita (National Association of State Mental Health Program Directors Research Institute, Inc.). Due to limited funding, state agencies focus on severe crisis treatment. There are 1.4 million children without health insurance in Texas (Children’s Defense Fund, 2006), and behavioral health services available to these children are limited.

There is recognition that some childhood mental illnesses can be prevented, and many can be prevented from causing long-term damage, with appropriate access to mental health services. By increasing access to mental health services for the youth, we are making an upfront investment in the healthy future of a child.

**Project Components:**
This project option does not have required components.

**Milestones and Metrics:**
Harris Health System has chosen project option 1.12.2: Enhance service availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care to best fit the scope and goals of this project.

- **Process Milestones and Metrics:**
  - P-4, P-4.1
  - P-6, P-6.1
  - P-10, P-10.1

- **Improvement Milestones and Metrics:**
  - I-11, I-11.1

**Unique Community Need Identification Numbers:**
The scope and goals of this project specifically address three of the identified community needs from the regional needs assessment. The project focuses on CN.3 and CN.18 by increasing access for pediatric and adolescent patients to behavioral health services. This aligns with CN.6 by addressing the importance of adequate access and behavioral health treatment for children and potential long term benefits.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This is not a new initiative for Harris Health System, however, this is an expansion of an existing service. This initiative will greatly enhance the services offered to this underserved population.
Related Category 3 Outcome Measure:
OD-6  Patient Satisfaction
IT-6.2  Percent improvement over baseline of patient satisfaction scores: Patients are getting timely care appointments and information

Reasons/rationale for selecting the outcome measure:
This measure focuses on patient satisfaction outcomes to ensure patients are receiving care and appointments in a timely manner for behavioral health services regardless of ability to pay. Harris Health System highly values our patients and will continuously work on opportunities for improvement. This outcome measure allows Harris Health to focus on improvements that value the patient as a whole and not only based on clinical indicators. We will begin to measure in DY4.

Relationship to other Projects:
The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

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

Project Valuation:
The goal of this project is to increase psychiatry and behavioral therapy staffing at existing pediatric locations within Harris Health System. Expanding pediatric and adolescent behavioral health services has the potential to help decrease the future need for inpatient behavioral health beds by addressing issues at earlier stages in life. Untreated behavioral health needs may lead to school failure, behavioral conflicts, and substance abuse; the longer the issues are left untreated, the more difficult and costly it is to provide effective treatment. The monetary cost of children’s mental health disorders in the U.S. is $247 billion annually (National Research Council). Building a strong comprehensive system to support children’s mental health initiatives is crucial. Key components include promoting early childhood mental health, policy development, integrating mental health into primary care settings, providing culturally and linguistically competent services, and collaborating with stakeholders in mental health, schools, families, and the community. The increase in provider staffing throughout the existing pediatric services network can ultimately meet the behavioral care needs of an additional eight thousand patients annually. We plan to add and expand services at 9 sites and see a cumulative total of 37,319 visits by end of DY5.
### Objective

**Enhance service availability of appropriate levels of behavioral health care: Expansion of Pediatric Behavioral Health Services**

**Harris Health System**

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

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-4]: Hire and train staff to operate and manage projects selected</td>
<td><strong>Milestone 3</strong> [P-4]: Hire and train staff to operate and manage projects selected</td>
<td><strong>Milestone 6</strong> [P-10]: Participate in meetings and/or learning collaboratives</td>
<td><strong>Milestone 9</strong> [P-10]: Participate in meetings and/or learning collaboratives</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-4.1]: Number of staff secured and trained</td>
<td><strong>Metric 1</strong> [P-4.1]: Number of staff secured and trained</td>
<td><strong>Metric 1</strong> [P-10.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP</td>
<td><strong>Metric 1</strong> [P-10.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP</td>
</tr>
<tr>
<td>Baseline: 1.3 FTE’s Psychiatrist 3.4 FTE’s Behavioral Therapist 0 FTEs support staff Goal: Hire and train additional: 1.2 FTE’s Psychiatrist 1.0 FTE Behavioral Therapist</td>
<td>Baseline: 1.3 FTE’s Psychiatrist 3.4 FTE’s Behavioral Therapist Goal: Hire and train additional: 2.2 FTE’s Psychiatrist 3.2 FTE’s Behavioral Therapist</td>
<td>Goal: Semi-annual Data Source: Meeting documentation; learning collaborative</td>
<td>Goal: Semi-annual Data Source: Meeting documentation; learning collaborative</td>
</tr>
<tr>
<td>Data Source: Staffing plan</td>
<td><strong>Milestone 3</strong> Estimated Incentive Payment: $1,640,546.67</td>
<td><strong>Milestone 6</strong> Estimated Incentive Payment: $1,645,315</td>
<td><strong>Milestone 9</strong> Estimated Incentive Payment: $2,038,761</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment (maximum amount): $4,511,350</td>
<td><strong>Milestone 4</strong> [P-6]: Establish behavioral health services in new community-based settings in underserved areas</td>
<td><strong>Milestone 7</strong> [P-4]: Hire and train staff to operate and manage projects selected</td>
<td><strong>Milestone 10</strong> [I-11]: Increased utilization of community behavioral healthcare</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-6]: Establish behavioral health services in new community-based settings in underserved areas</td>
<td><strong>Metric 1</strong> [P-6.1]: Number of new community-based settings where behavioral health services are delivered</td>
<td><strong>Metric 1</strong> [P-4.1]: Number of staff secured and trained</td>
<td><strong>Metric 1</strong> [P-11.1]: Percent utilization of community behavioral health services</td>
</tr>
<tr>
<td>Baseline: 0 Goal: 3 new sites Data Source: Business Plan</td>
<td>Baseline: 0 Goal: 1 new site, for a total of 4 new sites Data Source: Business Plan</td>
<td>Baseline: 1.3 FTE’s Psychiatrist 3.4 FTE’s Behavioral Therapist Goal: Hire and train additional: 2.4 FTE’s Behavioral Therapist</td>
<td>Goal: increase number of visits from DY4 by 40% (total 17,484 visits) Data Source: EMR</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $1,640,546.67</td>
<td>Milestone 4 Estimated Incentive Payment: $1,640,546.67</td>
<td>Total staff hired and trained: 3.7 FTE’s Psychiatrist 7.6 FTE’s Behavioral Therapist Data Source: Staffing Plan</td>
<td>Milestone 10 Estimated Incentive Payment: $2,038,761</td>
</tr>
<tr>
<td><strong>Milestone 3</strong> Estimated Incentive Payment: $1,640,546.67</td>
<td>Milestone 7 Estimated Incentive Payment: $1,645,316</td>
<td>Milestone 7 Estimated Incentive Payment: $1,645,316</td>
<td><strong>Milestone 9</strong> Estimated Incentive Payment: $2,038,761</td>
</tr>
<tr>
<td><strong>Milestone 4</strong> Estimated Incentive Payment: $1,640,546.67</td>
<td><strong>Milestone 7</strong> Estimated Incentive Payment: $1,645,316</td>
<td><strong>Milestone 7</strong> Estimated Incentive Payment: $1,645,316</td>
<td><strong>Milestone 9</strong> Estimated Incentive Payment: $2,038,761</td>
</tr>
<tr>
<td>Milestone 5 [I-11]: Increased utilization of community behavioral healthcare</td>
<td>Milestone 8 [I-11]: Increased utilization of community behavioral healthcare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1 [I-11.1]: Percent utilization of community behavioral healthcare services</strong>&lt;br&gt;Baseline: 5,877 visits&lt;br&gt;Goal: Increase number of visits from baseline by 25% (total 7,346 visits)&lt;br&gt;Data Source: EMR</td>
<td><strong>Metric 1 [I-11.1]: Percent utilization of community behavioral healthcare services</strong>&lt;br&gt;Goal: Increase number of visits from DY3 by 70% (total 12,489 visits)&lt;br&gt;Data Source: EMR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 5 Estimated Incentive Payment: $1,640,546.67</td>
<td>Milestone 8 Estimated Incentive Payment: $1,645,316</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Year 2 Estimated Milestone Bundle Amount: $4,511,350 | Year 3 Estimated Milestone Bundle Amount: $4,921,640 | Year 4 Estimated Milestone Bundle Amount: $4,935,947 | Year 5 Estimated Milestone Bundle Amount: $4,077,522 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5)*: $18,446,459
Project Option 1.12.4- Other- Enhance service availability of appropriate levels of behavioral health care: Expansion of Ambulatory Mental Health Services

Unique RHP Project ID: 133355104.1.10 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

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

Volume Statistics - FY2012

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

Intervention(s):
This project will enhance service availability of appropriate levels of behavioral health care by expanding mental health services in the ambulatory care setting. Therapists and psychiatrists will be added (13.4 Psychiatry and Behavioral Health FTEs) to existing Harris Health System health centers across Harris County.

Need for the project:
Hours and appointment availability is currently limited. There are only 4.5 Psychiatry FTEs and 12.6 Therapy FTEs in the health centers. The average wait time for an appointment is 9.5 weeks for a new and return appointment.

Target Population:
All patients within the system seeking behavioral health services may benefit from this project (Overall Payor Mix: Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

Category 1 or 2 expected patient benefits:
Our goals are to see 3,000 completed visits in DY3, 8,000 in DY4, and 12,000 in DY5, for a total of 23,000 visits from DY3-DY5.

Category 3 outcomes:
IT- 1.19: Our goal is to increase the percent of patients diagnosed with a serious mental illness that are adherent to prescribed medication treatment plan. The goals for rates A) and B) TBD based on baseline established in DY3.
Project Option 1.12.4- Other- Enhance service availability of appropriate levels of behavioral health care: Expansion of Ambulatory Mental Health Services

**Unique RHP Project ID:** 133355104.1.10 / Pass 1  
**Performing Provider Name/TPI:** Harris Health System / 133355104

**Project Description:**

_Harris Health System proposes to enhance service availability of appropriate levels of behavioral health care by expanding mental health services in the ambulatory care setting._

Therapists and psychiatrists will be added to existing Harris Health System health centers across Harris County. Currently, each of the targeted health centers offers mental services, but with limited hours and appointment availability. Mental health provider FTEs will be added to each of the health centers below, in existing underutilized space. Appointment availability and service hours within the boundaries of normal operating hours will be expanded.

**Goals and Relationship to Regional Goals:**

The goals of this project are to:

- Increase access to and capacity for mental health services in the ambulatory care setting
- Develop a mechanism for the identification of the mentally ill population within Harris Health community centers
- Improve medication adherence by monitoring pharmacy utilization
- Enhanced access to mental health services and the ability to track and monitor medication adherence promote a decrease in acute care and emergency center visit utilization and thereby lowers overall cost of care per patient

This project meets the following Region 3 goals:

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

Additional provider FTEs will increase access to a high-demand specialty care service in high-demand areas of underserved individuals. The health center is the appropriate setting for outpatient mental health needs. Harris Health System ensures that Harris County residents will receive care regardless of their ability to pay.

**Challenges:**

This project possesses challenges relative to the patient population and the data collection of medication adherence.

1. Initial identification of primary diagnosed patients with major serious mental illness
2. Cultural nuances and family dynamics that impact seeking treatment for mental health/major depression concerns
3. Retrieval of data relative to pharmacy utilization and patient medication adherence
4. Recruitment of sufficient psychiatrist to optimize patient capacity
5. Recruitment of mental health professionals to complement the psychiatrists’ case load for behavioral intervention and counseling services
Challenges will be addressed by working collaboratively with Harris Health’s academic medical school partners and graduate medical residency programs to secure psychiatrists for the mental health primary care expansion. Providing a clinical setting for residents will aid in securing future psychiatrists to sustain the program as attrition occurs. Recruitment of mental health professionals will be enhanced by internal and external recruitment efforts and in collaboration with the region’s academic partners.

An initial internal data retrieval of all patient encounters across the continuum for Harris Health patients, with a primary diagnosis of major depression or a diagnosis of another mental health concern (in accordance with DSM IV) will be conducted. Following identification of the patient population, a culturally sensitive program for patient contact and monitoring will be established in collaboration with the mental health team of professionals. A plan for retrieval of pharmacy utilization will be developed in conjunction with the Chief Pharmacy Officer and community health center staff pharmacists to ascertain medication for tracking and capacity and timeframes for reporting. Language barriers will be mitigated by the use of bilingual psychiatrists, mental health professionals, and ready access to patient interpretive services either on-site or telephonically.

5-Year Expected Outcome for Provider and Patients:
Over the course of the 5-Year Waiver, Harris Health System expects to realize:

- Increased access to mental health services in the ambulatory care setting.
- Increase the number of adults enrolled in a Harris Health Medical Home with a Serious Mental Illness (SMI) diagnosis
- Patients with a primary diagnosis of a SMI will have evidence of improved medication management

Starting Point/Baseline:
0 for this project, baseline will be established in DY3 with 3,000 completed visits.

Rationale:
Mental health concerns are attributed to 25% of the population in the US, and 50% will be treated for such at least once in a lifetime (CDC, 2011). Mental health, specifically major depression, bipolar disorder, and schizophrenia are the most common mental health disorders treated in the ambulatory care setting at Harris Health. Major depression is proven to be a concurrent disorder as a result of a chronic disease, and as an example, Harris Health has 47,000 patients with diabetes and Harris County has 9% of its 4 million residents with a diagnosis of diabetes (CDC, 2011).

Formulary dispensing includes serotonin specific reuptake inhibitors (SSRI) as part of the top 6 medications prescribed for mental health. Psychiatric assessment with associated medication and stabilization are essential, but therapists are required in order to provide counseling and education relative to coping skills, problem solving, and management of behavioral symptomatology. Psychiatric and mental health professional services are interdependent and relative to successful patient outcomes. Ready access to providers and therapists is crucial to permit timely de-escalation, clinical interventions, and promotion of mental health. Harris Health has geriatric treatment centers and mental health concerns in Texas according to the CDC (2008) accounts for as much as 14% in residents over the age of 50.
While Harris Health System offers mental health services, hours and appointment availability is currently limited. There are only 4.5 Psychiatry FTEs and 12.6 Therapy FTEs in the health centers.

**Project Components:**
The chosen project option does not have any required core components.

**Milestones & Metrics:**
- Process Milestones and Metrics- P-10 (P-10.1); P-X1 (P-X.1);
- Improvement Milestones and Metrics- I-X1 (I-X1.1)

**Unique community need identification number the project addresses:**
This project addresses the following community needs according to the community needs assessment:
- CN.2- Inadequate access to specialty care
- CN.3- Inadequate access to behavioral health care

**How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:**
Currently, Harris Health System offers limited mental health service availability in health centers. This project enhances the expansion of pediatric behavioral health services as well. In addition, it provides the ambulatory care providers that will support an expanded inpatient capacity and hospital-based service capacity at Harris Health System hospitals: Ben Taub General Hospital and LBJ General Hospital. Additionally, this initiative will track, monitor, and report on medication adherence for patients with a primary diagnosis of major depression.

**Related Category 3 Outcome Measure(s):**
OD-1 Primary Care and Chronic Disease Management
- IT-1.19 Antidepressant Management

**Reasons/rationale for selecting the outcome measure(s):**
Mental health, specifically major depression, bipolar disorder, and dysthymia, are the most common mental health disorders treated in the ambulatory care setting at Harris Health. Major depression is proven to be a concurrent disorder as a result of a chronic disease, and as an example, Harris Health has 47,000 patients with diabetes, and Harris County has 9% of its 4 million residents with a diagnosis of diabetes (CDC, 2011).

**Relationship to other Projects:**
The Harris Health projects of implementing a disease registry will aid in the identification of patients with a mental health diagnosis, predict utilization and cost, and also track medications prescribed and filled.

**Relationship to Other Performing Providers’ Projects in the RHP:**
The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a
focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

The cohabitation of primary care and behavioral health is an important focus of our region in order to treat the patient base with comprehensive physical and behavioral healthcare issues. There are multiple initiatives in our RHP plan that address this need and all can be found on the Region 3 Initiative Grid in the addendums. The outcome measures focused to screening measures and access of the patient base.

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

**Project Valuation:**
The goal of this project is to increase psychiatry and behavioral therapy staffing at current medical home primary care clinics, in existing underutilized space. All of the targeted health centers offer behavioral services; however the hours and appointment availability are limited. Service hours and appointment capacity will be expanded within each of the clinics. Enhanced access to mental health services and the ability to track and monitor medication adherence will promote a decrease in acute care and emergency center visit utilization, as well as potentially decrease the need for additional inpatient psychiatric beds, thereby lowering the overall cost of care. The increase in provider staffing throughout the existing primary care services network can ultimately meet the behavioral care needs of an additional 7,000 patients annually.


<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| 133355104.3.12 | **Antidepressant Management** | **Milestone 1** [P-X1]: Expand capacity by adding mental health providers in primary care settings  
**Metric 1** [P-X1.1]: Number of staff secured and trained  
Goal: Hire 10.4 Psychiatry and Therapy FTEs in DY2  
Data Source: Project records | **Milestone 2** [P-X1]: Expand capacity by adding mental health providers in primary care settings  
**Metric 1** [P-X1.1]: Number of staff secured and trained  
Goal: Hire 3 Psychiatry and Therapy FTEs in DY3 for a total of 13.4 FTEs  
Data Source: Project records | **Milestone 3** [I-X1]: Increase the number of completed visits with a primary diagnosis of serious mental illness treated in the primary care setting.  
**Metric 1** [I-X1.1]: Number of completed visits with a primary diagnosis of mental illness treated in the primary care setting  
Goal: 8,000 completed visits in DY4  
Data Source: EHR | **Milestone 4** [I-X1]: Increase the number of completed visits with a primary diagnosis of serious mental illness treated in the primary care setting.  
**Metric 1** [I-X1.1]: Number of completed visits with a primary diagnosis of mental illness treated in the primary care setting  
Goal: 12,000 completed visits in DY5  
Data Source: EHR  
Milestone 8 Estimated Incentive Payment: $2,391,905 |
| **Estimate Incentive Payment (maximum amount): $5,292,784** | **Milestone 5** [P-10]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.  
**Metric 1** [P-10.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP  
Goal: Participate in all semi-annual face-to-face meetings or seminars  
Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. | **Milestone 6** [I-X1]: Increase the number of completed visits with a primary diagnosis of serious mental illness treated in the primary care setting.  
**Metric 1** [I-X1.1]: Number of completed visits with a primary diagnosis of mental illness treated in the primary care setting  
Goal: 12,000 completed visits in DY5  
Data Source: EHR  
Milestone 8 Estimated Incentive Payment: $2,391,905 |
| **Milestone 7** [P-10]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.  
**Metric 1** [P-10.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP  
Goal: Participate in all semi-annual face-to-face meetings or seminars  
Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. | **Milestone 8** [I-X1]: Increase the number of completed visits with a primary diagnosis of serious mental illness treated in the primary care setting.  
**Metric 1** [I-X1.1]: Number of completed visits with a primary diagnosis of mental illness treated in the primary care setting  
Goal: 12,000 completed visits in DY5  
Data Source: EHR  
Milestone 8 Estimated Incentive Payment: $2,391,905 |
<table>
<thead>
<tr>
<th>13335104.1.10</th>
<th>1.12.4</th>
<th>N/A</th>
<th><strong>Enhance Service Availability of Appropriate Levels of Behavioral Health Care - Expansion of Ambulatory Mental Health Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Harris Health System</td>
<td>13335104</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>13335104.3.12</th>
<th>IT-1.19</th>
<th>Antidepressant Management</th>
</tr>
</thead>
</table>

**Year 2 (10/1/2012 – 9/30/2013):**

- Presentations, and/or meeting notes.
- Milestone 5 Estimated Incentive Payment: $2,895,465

**Year 3 (10/1/2013 – 9/30/2014):**

**Year 4 (10/1/2014 – 9/30/2015):**

- Milestone 7 Estimated Incentive Payment: $2,391,906

**Year 5 (10/1/2015 – 9/30/2016):**

**Year 2 Estimated Milestone Bundle Amount:** $5,292,784

**Year 3 Estimated Milestone Bundle Amount:** $5,774,143

**Year 4 Estimated Milestone Bundle Amount:** $5,790,929

**Year 5 Estimated Milestone Bundle Amount:** $4,783,811

**Total Estimated Incentive Payments for 4-Year Period:** (add milestone bundle amounts over Years 2-5): $21,641,667
Project Option 1.3.1- Implement/Enhance and Use Chronic Disease Management Registry Functionalities: Implement a Chronic Disease Management Registry

**Unique RHP Project ID:** 133355104.1.11 / Pass 1  
**Performing Provider Name/TPI:** Harris Health System / 133355104

**Project Summary:**

Provider:

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

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

**Intervention(s):**

This project will develop a chronic disease management registry to use system-wide to ensure providers and clinical staff has access to determine patient status and identify physical, psychosocial and emotional needs of the chronically ill patient.

**Need for the project:**

The purpose is to provide the ability to identify patients at risk based on chronic disease states and associated utilization patterns. When patients’ needs are identified then are educated and empowered to self-manage, quality improves, inappropriate utilization decreases, and the cost per capita declines.

**Target Population:**

All patients within the system with may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%), specifically those with chronic diseases to include diabetes, COPD, asthma, heart failure, and obesity.

**Category 1 or 2 expected patient benefits:**

Our DY4 goal is to improve upon baseline of patient identification in registry by 15%. Our DY5 goal is for 40% of patients in registry have at least 1 contact in the prior year period. The estimated total number of patients that would be managed within the registry would be > 10,000 patients.

**Category 3 outcomes:**

IT-3.2: Our goal is to reduce congestive heart failure 30 day readmission rates by 1% of baseline in DY4 and 5% of baseline in DY5
Project Option 1.3.1- Implement/Enhance and Use Chronic Disease Management Registry

Functionalities: Implement a Chronic Disease Management Registry

Unique RHP Project ID: 133355104.1.11 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104

Project Description:
Harris Health System will develop a chronic disease management registry to use system-wide to ensure providers and clinical staff has access to determine patient status and identify physical, psychosocial and emotional needs of the chronically ill patient. Electronic information sharing will promote a continuum of awareness of adherence to treatment plans, pharmacy, and primary and secondary care utilization. The purpose of the implementation of a disease registry is to provide the ability to identify patients at risk based on chronic disease states and associated utilization patterns that will facilitate the ability to identify gaps in service and deficits in patient understanding and self-management of their disease. When patients’ needs are identified then are educated and empowered to self-manage quality improves inappropriate utilization decrease and the cost per capita declines. The project will utilize the existing electronic medical record and enhance the capabilities to implement a comprehensive disease registry. The proposed will impact (based on historical data) greater than 700 patients within a one year period

Goal(s) and Relationship to Regional Goals:
The goals of this project are to:

- Identification of Harris Health patients at risk based on chronic disease process and severity of illness established by utilization of emergency center visits, acute care admissions and readmissions
- Identification of Harris Health patients who are at risk for decline in their respective chronic disease processes based on evidence relative to individual patient pharmacy utilization as indicative of adherence to treatment plan and ascertain barriers to adherence
- Stratify patients based on need relative to utilization indicating a deficit in education, instruction or support both financial and emotional
- Electronic reporting on ambulatory care sensitive conditions will delineate patient need for case management services to promote self-management

This project meets the following Region 3 goals:
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.
Challenges or Issues:
Population served by Harris Health has a literacy level averaging 5th grade
- Culturally diverse population to include Hispanics and African American who are predisposed to diabetes, hypertension, and obesity (Harris Health System Fact Sheet 2012)
  - Hispanic 57.4%
  - African American 26.3%
  - Caucasian 9.2%
  - Asian 4.8%
  - Other 2.2%
  - American Indian 0.2%
- Inability to identify patients proactively based on lack of cohort data specific to individual patients, disease processes and respective utilization

The project will address the above challenges by capture of individual demographic data in a searchable database that will be aligned with utilization, cohered to a disease process (s) and associated with NDC (pharmacy) utilization. Evaluation of the data will depict the penetration of chronic disease demographically and permit the specific patient centered programs for self-management and financial assistance to be availed to promote self-management and early intervention. Individual identification of need based on utilization and specific disease process will permit the development of patient specific intervention to address psychosocial barriers to care delivery.

5-year Expected Outcome for Provider and Patient:
Patients with chronic illness will have improved health, via management, the cost per patient is decreased due to decreased acute care and emergency visit utilization, and quality is improved via the proactive identification of patient need and access to same is available.

Starting Point/Baseline:
Because the disease registry project is a new endeavor, the baseline for this project is currently 0 patients enrolled in the registry. A baseline for patients registered will be established in DY 3 and will serve as the basis of our improvement targets for DY 4 and DY5.

Current status:
Harris Health per internal data has 47,000 patients in the served population and the top 5 diagnoses of chronic disease are heart failure, hypertension, obesity, depression, and chronic respiratory to include Chronic Obstructive Pulmonary Disease and asthma (October 2011-September 2012). Without a disease registry it is difficult to establish the incidence and prevalence of chronic disease.

Rationale:
Project option 1.3.1 is selected based on the need to implement a searchable comprehensive registry that will electronically be capable of reporting data to efficiently identify, and evaluate patients with chronic disease, and their associated utilization. Additionally the disease registry will provide data to analyze to address the reasons for emergency and visits and readmissions to acute care based on a deficit in the patient’s ability to self-manage their disease process. A disease registry also will promote the adaptation of existing or
implementation of new programs based on demographic data retrieved specific to chronic
disease and the ambulatory case sensitive conditions.

**Project components:**

a) Enter patient data into unique chronic disease registry. The patient clinical information to
include laboratory values, diagnostic testing and procedural interventions will be
extrapolated and electronically captured from the electronic medical record which will
interface with the disease registry software. Patient data will be captured utilizing
predetermined inclusion criteria, and entered into discrete data fields which will provide
the structure for entry into the disease registry. Based on data collected and retrieved the
patients will be identified based on place of service and provider. As a result each
patient’s unique data will be collected from any access point across the care continuum so
as to ascertain management of the chronic disease and associated professional and patient
interventions and outcomes.

b) Use registry data to proactively contact, educate, and track patients by disease status, risk
status, self-management status, community and family need.

c) Use registry reports to develop and implement targeted QI plan. Reports will be
electronically produced as part of key performance indicator dashboard and will be
reviewed at a minimum by the Ambulatory Care Committee, the Quality Governance
Council, and as applicable the Board of Managers.

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

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

- CN.8 – High rates of inappropriate emergency department utilization
- CN.9- High rates of preventable hospital readmissions
- CN.10- High rates of preventable hospital admissions
- CN.11 – High rates of chronic disease and inadequate access to treatment programs and
  services for illnesses associated with chronic disease including:
  - Asthma
  - Diabetes
  - Obesity
  - Cardiovascular
  - Aids/HIV
  - Cancer

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

The project is a new initiative for Harris Health and does not exist today in any form. The
current electronic health record does not capture data in patient categories or cohort data that is
electronically available to the end user to drive decision making, to meet the needs of the
community with chronic illness.
**Related Category 3 Outcome Measure(s):**
- OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates
- IT-3.2 Congestive Heart Failure Admission rate (CHF)- PQI #8

Category 3 outcome measures are related to primary care, management of chronic disease and cost. The rationale for selecting IT 3.2 is relevant to the high volume of patients at Harris Health diagnosed with ambulatory care sensitive conditions pertinent to chronic disease such as COPD, asthma, Hypertension, diabetes and heart failure. An active disease registry will promote the management of patients via their identification in the population, patterns of utilization and their ability to self-manage thereby preventing inappropriate admissions or readmissions for the ambulatory care sensitive condition.

**Relationship to other Projects:**
The sheer volume of population, as well as the complexity of patient conditions, dictates the need of numerous disease registries in our region to properly identify and manage chronic conditions. The concept is utilized consistently throughout our region in order to help achieve milestones and outcomes specific to patient conditions. All disease registries presented have a similarity in concept but are unique in the sense of condition or patient population focus. The Region 3 initiative grid in the addendum reflects direct relations between all projects.

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

**Project Valuation:**
The purpose of the implementation of a disease registry is to provide the ability to identify patients at risk based on chronic disease states and associated utilization patterns that will facilitate the ability to identify gaps in service and deficits in patient understanding and self-management of their disease. Patients with chronic illness will have improved health, via education and case management, the cost per patient is decreased due to decreased acute care and emergency visit utilization, and the patient’s quality of life is improved. Harris Health internal data for the most recent year has 47,000 patients with one or more of the top 5 diagnoses of chronic disease – heart failure, hypertension, obesity, depression, and chronic respiratory. With a disease registry allowing us to establish clear incidence and prevalence data, the cost saving opportunity related to the potential improved management of these conditions is substantial.
**Implement/Enhance and Use Chronic Disease Management Registry Functionalities: Implement a Chronic Disease Management Registry**

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>133355104.1.11</th>
<th>1.3.1</th>
<th>1.3.1 (A-D)</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 [P-1]:</strong> Identify one or more target patient populations diagnosed with selected chronic disease(s) (e.g. diabetes, CHF, COBP, etc.) or with Multiple Chronic Conditions (MCCs).</td>
<td><strong>Metric 1 [P-1.1]:</strong> Documentation of patients to be entered into the registry</td>
<td><strong>Milestone 2 [P-2]:</strong> Review current registry capability and assess future needs.</td>
<td><strong>Metric 1 [P-2.1]:</strong> Documentation of review of current registry capability and assessment of future registry needs</td>
<td><strong>Baseline/Goal:</strong> Registry reports</td>
<td><strong>Data Source:</strong> Registry</td>
<td><strong>Milestone 2 Estimated Incentive Payment:</strong> $1,316,069</td>
<td><strong>Milestone 6 [I-15]:</strong> Increase the percentage of patients enrolled in the registry.</td>
<td><strong>Metric 1 [I-15.1]:</strong> Percentage of patients in the registry</td>
</tr>
</tbody>
</table>

**Milestone 1 Estimated Incentive Payment:** $4,825,421

**Milestone 2 Estimated Incentive Payment:** $1,316,069

**Milestone 3 Estimated Incentive Payment:** $1,316,069

**Milestone 3 Estimated Incentive Payment:** $1,316,069

**Milestone 6 Estimated Incentive Payment:** $2,639,790

**Milestone 8 Estimated Incentive Payment:** $4,361,391
### Implement/Enhance and Use Chronic Disease Management Registry Functionalities: Implement a Chronic Disease Management Registry

<table>
<thead>
<tr>
<th>Outcome Measure(s):</th>
<th>133355104.3.13</th>
<th>IT-3.2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Congestive Heart Failure 30 Day Readmission Rate</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Outcome Measure(s)</th>
<th>Baseline</th>
<th>Goal</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
<td>100% documentation of training for relevant clinicians</td>
<td>100% documentation of training for relevant clinicians</td>
<td>Human Resources or training program materials</td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 4 [P-6]:**
Conduct staff training on populating and using registry functions.

**Metric 1 [P-6.1]:**
Documentation of training programs and list of staff members trained, or other similar documentation

- **Baseline:** Zero documentation
- **Goal:** 100% documentation of training for relevant clinicians
- **Data Source:** Human Resources or training program materials

Milestone 4 Estimated Incentive Payment: $1,316,069

**Milestone 5 [P-X]:** Establish baseline number of patients enrolled in the registry

**Metric 1 [P-X.1]:**
Documentation of number of patients enrolled in the registry

- **Baseline:** 0 patients enrolled in DY2
- **Goal:** Provide documentation of number of patients enrolled in the registry
- **Data Source:** EHR

Milestone 7 Estimated Incentive Payment: $2,639,790

---

**Regional Healthcare Partnership Plan**

Region 3

---

240
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>133355104.3.13</th>
<th>IT-3.2</th>
<th>Congestive Heart Failure 30 Day Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong></td>
<td>(10/1/2012 – 9/30/2013)</td>
<td>Milestone 5 Estimated Incentive Payment: $1,316,069</td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong></td>
<td>(10/1/2013 – 9/30/2014)</td>
<td>Year 3 Estimated Milestone Bundle Amount: $5,264,276</td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong></td>
<td>(10/1/2014 – 9/30/2015)</td>
<td>Year 4 Estimated Milestone Bundle Amount: $5,279,579</td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong></td>
<td>(10/1/2015 – 9/30/2016)</td>
<td>Year 5 Estimated Milestone Bundle Amount: $4,361,391</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5): $19,730,667*
Project Option 1.10.4- Implement other evidence-based project to enhance performance improvement and reporting capacity: Center of Innovation

Unique RHP Project ID: 133355104.1.12 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

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

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

Intervention(s):
This project will establish a Center of Innovation to expand quality improvement capacity through people, processes and technology so that the resources are in place to conduct, report, drive and measure quality improvement.

Need for the project:
There is strong rationale and evidence to suggest that a comprehensive Center for Innovation in Healthcare would increase the value of healthcare (best care with lower cost).

Target Population:
The population will consist of thousands of patients that will directly benefit from the innovations in patient safety and quality. Amplification of these projects in the region and nationally will exponentially benefit thousands more. The center will target Hospital-acquired Venous Thrombembolism (VTE) as the initial project, which will affect over 1,000 inpatients. This project will be followed by dozens of individual projects focusing on inpatient, outpatient, and community programs that would improve the value of healthcare for thousands of additional patients. (Overall Payor Mix: Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

Category 1 or 2 expected patient benefits:
The project seeks to demonstrate ≥2 performance activities in DY 4 and ≥5 in DY5 that were designed and implemented based on the data in the reports and efforts of the Center of Innovation. This project would target an estimated 1000+ patients.

Category 3 outcomes:
IT-4.6 Hospital-acquired Venous Thrombembolism (VTE) 257: Our goal is to decrease the number of cases of VTE from baseline by 2% in DY4 and 5% in DY5.
Project Option 1.10.4- Implement other evidence-based project to enhance performance improvement and reporting capacity: Center of Innovation

**Unique RHP Project ID:** 133355104.1.12 / Pass 1  
**Performing Provider Name/TPI:** Harris Health System / 133355104

**Project Description:**

*Harris Health System proposes to establish a Center of Innovation to expand quality improvement capacity through people, processes and technology so that the resources are in place to conduct, report, drive and measure quality improvement.*

In order to respond to the rapidly changing industry, innovation must be at the center of care delivery redesign, competitive strategy, and the development of internal resources. The Center of Innovation in Healthcare will serve as a platform for transformational change to create better value in healthcare. The innovations resulting from Harris Health System’s Center of Innovation will be centered around patients in the hospital, in outpatient settings, and with partners in the community. The implementation activities entail redesign of healthcare delivery processes, team building, care coordination, physician and nursing training and education of stakeholders.

Central staff at the institute comprised of healthcare leaders with expertise in the science of healthcare delivery, innovation, public health, systems engineers, information technology, community leaders and patients, will be created to innovate, collaborate and assist in delivering concepts to transform the delivery of care in our region and share nationally. The implementation activities would require support of the center design team of 15-20 experts in the science of healthcare delivery, patient safety, systems engineering, information technology, public health, and social services among others. The center would also require a facility for the core design team and 4-6 meeting rooms for team meetings. Administrative staff will be needed for coordination of activities. The first 12 months would also involve training of key physician and nursing leaders in the core concepts of patient safety and quality improvement to build a culture receptive to innovation. Additional support may include transportation for patient and community members to the facility; travel costs to learn from successful sustained programs with high impact; additional training for team members. The existing physician and nursing expertise would serve as a foundation for the initial design and implementation teams.

The center will define high impact opportunities in patient safety, clinical effectiveness of evidence based best practices, population health, care coordination and unmet patient needs in Medicaid and uninsured patients. The center design team will partner with healthcare providers, patients and other stakeholders to innovate and pilot the implementation. The innovation will require rapid assessment and modification cycles, clear metrics and local support for change through partnership between the local and center design team. A comprehensive evaluation of the innovation by the center will drive the continuous PDSA cycles until the impact is sustained. Replication of the successful innovation will be carried out throughout the organization. The science of innovation will be amplified by dissemination of the new knowledge.

This initiative is most suited to be initiated in Harris County because of: (a) the local expertise in the science of healthcare delivery, public health, information technology in reducing patient errors, and healthcare systems engineering (b) high rate of uninsured and Medicaid patients in the county (c) the international expertise at UT Health (via the Academy of Patient Safety and Clinical Effectiveness and the Center for Healthcare Quality and Safety, (d) long history of partnerships with national organizations (IHI, UHC, AHRQ, NQF) (e) the potential for rapid dissemination and implementation of the program throughout the country and nationally.
Goal(s) and Relationship to Regional Goal(s):
The goals of this project are to:

- Establish a Center of Innovation to leverage information technology, financial data, clinical knowledge, and human resources to implement performance improvement activities and promote a culture of innovation across the Harris Health System.
- Hire and train Center of Innovation quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes.
- Enhance performance improvement and reporting capacity across the Harris Health System.
- Improve hospital acquired Venous Thrombembolism (VTE) rates at Harris Health System.

This project meets the following Region 3 goals:

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

The Center of Innovation will work to develop and instill a culture of transformation and innovation within the Harris Health System through promotion of creativity and facilitation of collaboration, calculated risk-taking, and problem solving. The efficient and effective use of IT and clinical best practices will be ensured by staff to be hired and trained in quality and efficiency improvement principles, such as Lean/Six Sigma. Best practices will be shared at face-to-face meetings within the region and the Center of Innovation will participate in learning events with the possibility of presenting findings.

Challenges and how we will address them:
The primary challenges will be:

a) Creating a culture for rapid implementation and sustainability
b) Integrating data with national benchmarking programs in patient safety, mortality, and hospital costs
c) Obtaining accurate, real-time data to evaluate the effectiveness of the program

Harris Health System will create a culture for rapid implementation and sustainability through, dedicated, highly-skilled resources and support from executive leadership. Data will be integrated with currently used benchmarking programs at Harris Health, while the organization continuously seeks opportunities to move toward the most relevant benchmarking programs for the organization. Data needs will be met by the dedicated efforts of the internal information technology department to achieving accurate, timely data.

5-Year Expected Outcome for Provider and Patients:
Over the course of the 5-Year Waiver, Harris Health System expects to realize:

- A culture of ongoing transformation and innovation that is supported by a Center of Innovation staffed by highly-skilled healthcare workers capable of impacting clinical and operational outcomes in a way that aligns with the strategic goals of the organization.

Starting Point/Baseline:
The Center for Innovation is a new initiative for Harris Health System; thus, the baseline will be 0 for all milestones and metrics.
**Rationale:**

There is strong rationale and evidence to suggest that a comprehensive Center for Innovation in Healthcare would increase the value of healthcare (best care with lower cost). Centers of healthcare innovation at Cincinnati Children’s Hospital, UCLA Medical Center, Geisinger Health System and the programs such as UT Health’s program for chronically ill children piloted by Dr. Tyson are excellent references. The success of these programs demonstrates high reliability organizations in patient safety, clinical effectiveness, cost of care and integration of nontraditional community resources to improve health. These centers have reduced patient harm, improved mortality, reduced patient readmissions and emergency room visits, improved patient satisfaction and reduced disparities in healthcare delivery.

**Project Components:**

Not applicable / Project option 1.10.4 does not have components.

**Milestones & (Metrics):**

- Process Milestones and Metrics- P-1 (P-1.1); P-2 (P-2.1); P-4 (P-4.1); P-6 (P-6.1; P-6.2); P-9 (P-9.1)
- Improvement Milestones and Metrics- I-10 (I-10.2)

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

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

- CN.9- High rates of preventable hospital readmissions
- CN.10: High rates of preventable hospital admissions

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

The Harris Health System currently does not have a Center of Innovation or another similar initiative.

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

OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions

- IT-4.6 Hospital Acquired Venous Thrombembolism (VTE) rates

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

Sustained reduction and elimination of healthcare associated infections will require healthcare redesign. The center of innovation will provide expertise in systems engineering, science of healthcare delivery, information technology, human factors, and other quality improvement expertise to build better processes in central line maintenance and utilization to reduce hospital acquired infections (VTEs). Process milestones P-1 through P-3 develops the infrastructure for evaluation of people and processes and develops quality improvement and clinical effectiveness expertise. A baseline rate (P-2) for VTEs at Harris Health System will also be established in DY2 for performance purposes.

The Innovation Center will design and set new processes in place and rapidly test and re-innovate as data reveals the need for modifications in Process Milestone 3. The infrastructure will be amplified from 1 hospital to 3 hospitals in DY4. Improvement target for DY4 will be a 2% reduction of VTEs overall between the 3 hospitals. As the model undergoes continuous quality improvement, the improvement will exceed 5% reduction of VTEs overall.
**Relationship to other Projects:**
Innovation is key to the transformation of healthcare in our community. The consistency of innovation in our region allows for increased improvements based on research trends, patient need, and provider availability. The waiver funding allows for innovation in specific areas and all innovative projects included in the plan are similar in the fact of program redesigns for historic treatments, and focus to chronic condition outcome measures such as central line infections. The Region 3 initiative grid in the addendum can provide a side by side comparison of all projects that directly relate to innovation.

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

**Project Valuation:**
The goal of the center is to define high impact opportunities in patient safety, clinical effectiveness of evidence based best practices, population health, care coordination and unmet patient needs in Medicaid and uninsured patients. The center design team will partner with healthcare providers, patients and other stakeholders to develop innovation strategies and plans, and pilot the implementation. As noted earlier, centers of healthcare innovation at other prominent healthcare organizations are excellent references. The success of these programs demonstrates high reliability organizations in patient safety, clinical effectiveness, cost of care and integration of nontraditional community resources to improve health. These centers have reduced patient harm, improved mortality, reduced patient admissions, readmissions and emergency room visits, improved patient satisfaction and reduced disparities in healthcare delivery.
<table>
<thead>
<tr>
<th>133355104.1.12</th>
<th>1.10.4</th>
<th>N/A</th>
<th>IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY: CENTER FOR INNOVATION</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>133355104.3.14</td>
<td>IT-4.6</td>
<td>Hospital Acquired Venous Thromboembolism (VTE) rates</td>
</tr>
</tbody>
</table>

**Year 2 (10/1/2012 – 9/30/2013)**

**Milestone 1 [P-1]:** Establish a performance improvement office to collect, analyze, and manage real-time data to monitor the improvement trajectory and improvement activities across the Performing Provider’s delivery system

**Metric 1 [P-1.1]:** Documentation of the establishment of performance improvement office
- **Baseline:** Center of Innovation does not exist at Harris Health System
- **Goal:** Establish the Center of Innovation at Harris Health System and provide documentation of plan for staffing and functional capabilities
- **Data Source:** HR documents, office policies and procedures

**Milestone 1 Estimated Incentive Payment (maximum amount):** $8,942,808

**Year 3 (10/1/2013 – 9/30/2014)**

**Milestone 2 [P-6]:** Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends)

**Metric 1 [P-6.1]:** Increase number of staff trained in quality and efficiency improvement principles
- **Baseline:** 0 staff hired and trained in DY2
- **Goal:** Hire and train Center of Innovation staff in quality and efficiency improvement principles
- **Data Source:** HR, training programs

**Metric 2 [P-6.2]:** Increase number of data analysts hired who are responsible for collecting and analyzing real-time data to measure improvement and trends to drive rapid-cycle performance improvement.
- **Baseline:** 0 data analysts hired in DY3
- **Goal:** Hire data analysts for Center of Innovation
- **Data Source:** HR, job descriptions

**Year 4 (10/1/2014 – 9/30/2015)**

**Milestone 4 [I-10]:** Enhance performance improvement and reporting capacity.

**Metric 1 [P-10.2]:** Demonstrate how quality reports are used to drive performance improvement.
- **Goal:** Demonstrate ≥2 performance improvement activities that were designed and implemented based on the data in the reports and efforts of the Center of Innovation to improve patient safety or quality of care
- **Data Source:** HR, training program materials (including documentation of the number of hours of training required).

**Milestone 4 Estimated Incentive Payment:** $3,261,494.67

**Year 5 (10/1/2015 – 09/30/2016)**

**Milestone 5 [P-6]:** Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends)

**Metric 1 [P-6.1]:** Increase number of staff trained in quality and efficiency improvement principles

**Milestone 5 Estimated Incentive Payment:** $2,694,278.33

**Milestone 8 [P-6]:** Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends)

**Metric 1 [P-6.1]:** Increase number of staff trained in quality and efficiency improvement principles
- **Baseline:** Staff hired and trained in Regional Healthcare Partnership Plan Region 3

**Milestone 7 [I-10]:** Enhance performance improvement and reporting capacity.

**Metric 1 [P-10.2]:** Demonstrate how quality reports are used to drive performance improvement.
- **Goal:** Demonstrate ≥5 performance activities that were designed and implemented based on the data in the reports and efforts of the Center of Innovation to improve patient safety or quality of care
- **Data Source:** HR, training program materials (including documentation of the number of hours of training required).

**Milestone 7 Estimated Incentive Payment:** $2,694,278.33
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>IMPLEMEN OTHER EVIDENCE-BASED PROJECT TO ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACI</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>133355104.1.12</td>
<td>1.10.4</td>
<td>IMPLEMEN OTHER EVIDENCE-BASED PROJECT TO ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACI</td>
<td>N/A</td>
</tr>
<tr>
<td>Harris Health System</td>
<td>133355104</td>
<td>IMPLEMEN OTHER EVIDENCE-BASED PROJECT TO ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACI</td>
<td>N/A</td>
</tr>
<tr>
<td>133355104.3.14</td>
<td>IT-4.6</td>
<td>IMPLEMEN OTHER EVIDENCE-BASED PROJECT TO ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACI</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Hospital Acquired Venous Thrombembolism (VTE) rates**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$4,878,061.50</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 3 [P-2]: Establish a program for trained experts on process improvements to mentor and train other staff, including front-line staff, for safety and quality care improvement. All staff trained in this program should be required to lead an improvement project in their department within 6 months of completing their training.**

**Metric 1 [P-2.1]: Train the trainer program established**
- Baseline: Train the trainer program not established in DY2
- Goal: Establish program and provide documentation
- Data Source: HR, training program materials (including documentation of the number of hours of training required).

**Milestone 3 Estimated Incentive Payment: $4,878,061.50**

**Milestone 4 [P-3]: Establish a program for trained experts on process improvements to mentor and train other staff, including front-line staff, for safety and quality care improvement.**

**Metric 2 [P-3.1]: Train the trainer program established**
- Baseline: Train the trainer program not established in DY2
- Goal: Establish program and provide documentation
- Data Source: HR, training program materials (including documentation of the number of hours of training required).

**Milestone 4 Estimated Incentive Payment: $4,878,061.50**

**Milestone 5 [P-4]: Participate in quality improvement conferences, webinars, learning sessions or other venues**

**Metric 1 [P-4.1]: Number of learning events attended and number of learning events at which a presentation was delivered.**
- Goal: Attend and present at learning events; Provide documentation
- Data Source: Learning events’ agendas, abstracts or materials related to provider’s presentation

**Milestone 5 Estimated Incentive Payment: $3,261,494.67**

**Milestone 6 [P-9]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.**

**Metric 1 [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.**
- Baseline: No participation in DY3

**Milestone 6 Estimated Incentive Payment: $2,694,278.33**

**Milestone 7 [P-1]: Participate in quality improvement conferences, webinars, learning sessions or other venues.**

**Metric 2 [P-1.2]: Increase number of data analysts hired who are responsible for collecting and analyzing real-time data to measure improvement and trends and to drive rapid-cycle performance improvement.**
- Baseline: Data analysts hired in DY3
- Goal: Hire data analysts for Center of Innovation
- Data Source: HR, job descriptions

**Milestone 7 Estimated Incentive Payment: $2,694,278.33**

**Milestone 8 [P-5]: Participate in/present to face-to-face meetings or seminars organized by the RHP.**

**Metric 1 [P-5.1]: Participation in semi-annual face-to-face meetings or seminars organized by the RHP.**
- Baseline: No participation in DY3

**Milestone 8 Estimated Incentive Payment: $2,694,278.33**

**Milestone 9 [P-6]: Participate in quality improvement conferences, webinars, learning sessions or other venues.**

**Metric 2 [P-6.2]: Increase number of data analysts hired who are responsible for collecting and analyzing real-time data to measure improvement and trends and to drive rapid-cycle performance improvement.**
- Baseline: Data analysts hired in DY3
- Goal: Hire data analysts for Center of Innovation
- Data Source: HR, job descriptions

**Milestone 9 Estimated Incentive Payment: $2,694,278.33**

**Milestone 10 [P-7]: Participate in quality improvement conferences, webinars, learning sessions or other venues.**

**Metric 3 [P-7.3]: Increase number of data analysts hired who are responsible for collecting and analyzing real-time data to measure improvement and trends and to drive rapid-cycle performance improvement.**
- Baseline: Data analysts hired in DY3
- Goal: Hire data analysts for Center of Innovation
- Data Source: HR, job descriptions

**Milestone 10 Estimated Incentive Payment: $2,694,278.33**

**Milestone 11 [P-8]: Participate in quality improvement conferences, webinars, learning sessions or other venues.**

**Metric 4 [P-8.4]: Increase number of data analysts hired who are responsible for collecting and analyzing real-time data to measure improvement and trends and to drive rapid-cycle performance improvement.**
- Baseline: Data analysts hired in DY3
- Goal: Hire data analysts for Center of Innovation
- Data Source: HR, job descriptions

**Milestone 11 Estimated Incentive Payment: $2,694,278.33**
<table>
<thead>
<tr>
<th>Outcome Measure(s):</th>
<th>Hospital Acquired Venous Thromboembolism (VTE) rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.10.4</td>
<td>IT-4.6</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
</tr>
<tr>
<td>(10/1/2012 – 9/30/2013)</td>
<td>(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Goal: Participate at least twice per year</td>
<td></td>
</tr>
<tr>
<td>Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td></td>
</tr>
<tr>
<td>Milestone 6 Estimated Incentive Payment: $3,261,494.67</td>
<td></td>
</tr>
</tbody>
</table>

Year 2 Estimated Milestone Bundle Amount: $8,942,808
Year 3 Estimated Milestone Bundle Amount: $9,756,123
Year 4 Estimated Milestone Bundle Amount: $9,784,484
Year 5 Estimated Milestone Bundle Amount: $8,082,835

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $36,566,250
Harris County Hospital District Ben Taub General Hospital
Pass 2
Project Option 1.9.2-Improve access to specialty care: Increase access to outpatient Physical and Occupational Therapy specialty services

Unique RHP Project ID: 133355104.1.13 / Pass 2
Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

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

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

Intervention(s):
This project will increase the number of outpatient physical and occupational therapy providers in order to improve access and meet unmet demand for patients who are being referred for services from NCQA medical homes and specialty clinics.

Need for the project:
With current staffing, 1040 new patients per month on average are appointed. This is compared to the total number of referrals received which is 2487. Based on the current average monthly referral volume and the Physical and Occupational Therapy provider panel capacity it was determined that an additional 12 FTE’s are required to increase access.

Target Population:
Any patient appropriate for outpatient physical and/or occupational therapy within the system may benefit from this project (Overall payor mix: Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

Category 1 or 2 expected patient benefits:
Our goals are to increase the number of patients appointed per month by specialty Physical and Occupational Therapy services by 510 and increase the number of FTEs by 12.

Category 3 outcomes:
IT-10.1: Our goal is to improve quality of life (QOL) scores to greater than 50 at discharge from therapy for at least 10% of the patients seen in DY4 and for at least 20% of the patients seen in DY5.
Project Option 1.9.2-Improve access to specialty care: Increase access to outpatient Physical and Occupational Therapy specialty services

**Unique RHP Project ID:** 133355104.1.13 / Pass 2

**Performing Provider Name/TPI:** Harris Health System / 133355104

**Project Description:**

*Harris Health System Rehabilitation Services proposes to increase the number of outpatient physical and occupational therapy providers in order to improve access and meet unmet demand for patients who are being referred for services from NCQA medical homes and specialty clinics.*

This project will increase the capacity to provide outpatient physical and occupational therapy services and the availability of therapy providers to increase access for patients referred from primary care providers to the underserved areas of Harris County, primarily low-income, uninsured and Medicaid populations. Outpatient Physical Therapy and Occupational Therapy (PT and OT) services are targeted to populations who are at risk for impairments in activities of daily living resulting from a lack of access to specialty care. The project will improve access and expand current outpatient physical and occupational therapy services that would result in improved quality of life by persons served.

The Harris Health System Rehabilitation Services and Child Life Department serves 13 community health clinics (Medical Homes) and the specialty clinics at Ben Taub General Hospital, Lyndon B. General Hospital, and Quentin Mease Community Hospital. With current staffing 1040 new patients per month on average are appointed. This is compared to the total number of referrals received which is 2487. The average monthly referral volume by discipline is as follows:

- **Medical Home Average Monthly referrals**
  - Physical Therapy: 1592
  - Occupational Therapy: 285
  - Total: 1877

- **Specialty Clinic Average Monthly referrals**
  - Physical Therapy: 412
  - Occupational Therapy: 198
  - Total: 610

- **Total number of patients seeking therapy per month:**
  - 2487

- **Total number of patients currently appointed per month:**
  - 1040

- **Total number of patients who are unable to receive services per month:**
  - 1447

- **Additional patients to be served per month with additional FTE’s:**
  - 510

Based on the current average monthly referral volume and the Physical and Occupational Therapy provider panel capacity it was determined that an additional 12 FTE’s are required to
increase access. The department currently has 30.5 funded FTE’s as compared to a need for 42.5 FTE’s required to provide services referred to by a primary care physician’s order.

A six-month pilot was conducted from January 16, 2012 to July 16, 2012 to conduct a gap analysis for services provided and to formally define the role of physical and occupational therapists in the medical home. The results of the pilot are as follows:

1. PT’s and OT’s are integral part of the medical home patient care team as evidenced by their role in management of musculoskeletal and neuromuscular disorders.
2. New business model of care should be implemented to support NCQA Standards.
3. Access to care was identified as the major barrier to improved patient outcomes.

Successful completion of the pilot resulted in approval from Harris Health Leadership to adopt new medical home business model so that all referred patients have access and NCQA Standards can be adhered to. It was determined that access to specialty care (PT and OT) needs to be addressed to improve the quality of life of persons served.

The project will improve access to specialty care by providing an additional XX 12 PT and OT providers to the Rehabilitation Services department and by adding additional outpatient therapy treatment space near the referring clinics.

| Target Zip Codes: |
|------------------|-----------------|------------------|------------------|------------------|
| 77030 | 77088 | 77009 | 77018 | 77056 |
| 77026 | 77039 | 77012 | 77074 | 77099 |
| 77004 | 77520 | 77047 | 77028 | 77338 |

Goals and Relationship to Regional Goals:

The goal of this project is to use physical therapists, and occupational therapists to provide specialty care to patients who have impaired functional mobility and activities of daily living due to decreased quality of life. Once referred from a primary care physician, patients will have access to qualified rehabilitation professionals who will provide an individualized treatment plan based on the diagnosis and impairments identified from an evaluation. Early intervention and appropriate access to care will result in improved health outcomes because treatment can be delivered in an acute phase of the patient’s disorder as opposed to the chronic state that often occurs because of delayed access.

Project Goals:

- Increase the number of patients appointed per month by specialty Physical and Occupational Therapy services by 510.
- Improve the health outcomes of referred patients through improved access to specialty Physical and Occupational Therapy services.
- Decrease barriers to access to specialty Physical and Occupational Therapy services by placing additional staff and clinics in underserved areas of Harris County

This project meets the following regional goals:

- Transform healthcare delivery from a tertiary care model of episodic care to a primary/secondary model of patient-centered, coordinated care model of care by integrating Physical and Occupational therapy services within the medical home model. This will improve health outcomes, and reduce health care costs by increasing access to specialty care services.
Build on a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

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

Increasing the number of Physical and Occupational therapy staff will not only increase access to our patients who are in need of these specialty services, but it will also increase access to our medical home leadership and staff for improved communication, education and population management.

**Challenges:**
- Highly competitive hiring market, creating challenges in finding staff to fill the newly created positions.
- Finding innovative ways to mentor and integrate new staff into the larger health system due to geographical separation.
- Lack of education to physicians and specialty care providers about how to assess and refer patients to Physical and Occupational Therapy services.

Harris Health’s Rehabilitation Services department has an excellent reputation in the city and state for staff that are highly trained and specialized providers. This attracts therapists from several educational institutions that seek employment with Harris Health to be mentored and to serve a diverse patient population. In addition, the department has an active student program that allows individuals to be trained within our system which further attracts recent graduates to seek employment with our department. Currently there are no vacant positions in the outpatient rehabilitation services department. Due to the additional locations being separate from the current staff, a mentoring program will be developed. This mentoring program will involve experienced therapists to rotate initially to the location for orientation and mentoring. Then a rotation of staff will occur annually for ongoing mentoring and development. In addition the rehabilitation services department has a well-established education program for its entire staff that occurs throughout the year. With this program, each of the referring clinics will be assigned a lead contact therapist to oversee the needs of the clinic and its physicians. This lead therapist will attend physician meetings and work closely with the physicians to provide ongoing education on the specific population seen at each clinic. In addition, the physicians will have direct contact with the lead therapist assigned to the clinic via phone or electronic communication at all times. With these strategies, the challenges identified can be overcome.

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

Harris Health System Outpatient Rehabilitation Services expects to improve access to care for patients referred to specialty Physical and Occupational therapy care. Barriers to access to care will be reduced through geographically located clinics in underserved areas. Additionally, it is expected that patients seeking specialty Physical and Occupational Therapy services will have an increased quality of life through earlier intervention. Expected outcomes will relate to the project goals described above.
**Starting Point/Baseline:**

With the current 30.5 funded FTE’s the physical therapy and occupational therapy services are able to provide care for approximately 776 individuals seeking physical therapy and 264 individuals seeking occupational therapy per month for a total of 1,040 individuals served per month. The current number of referrals per month from primary care physicians total 2,487, this leaves a disparity of 1,447 individuals not having access to the specialty care of physical therapy and occupational therapy. In addition, the physical therapy and occupational therapy services are provided at two locations at LBJ General Hospital and Quentin Mease Hospital limiting access to patients that live in the western part of the Harris County due to a variety of barriers, including, but not limited to transportation. To serve the individuals not currently able to access services, an additional 12 FTE’s will be needed, including 10 physical therapists and 2 occupational therapists. The total acquisition of these additional FTE’s would occur over a 3 year period.

**Rationale:**

A large number of patients, who are enrolled in Medicaid, are uninsured or underinsured in Harris County are not receiving Physical therapy and Occupational Therapy services due to limited access. Currently there are only two outpatient therapy clinics in the Harris Health System and both are more centrally located. This leaves much of the county without local therapy services. The proposed clinic locations will be located in underserved areas of Harris County where access to specialty Physical and Occupational Therapy services is limited.

**Project Components:**

a) **Increase service availability with extended hours:** The clinics would operate similarly to the current clinics which have extended hours from 7 am to 5:30 pm.

b) **Increase number of specialty clinic locations:** This program would offer two additional locations located in underserved areas of the county either in existing community health clinics or in a local existing commercial structure. Additional staff will be hired to operate these clinics.

c) **Implement transparent, standardized referrals across the system:** Due to the integrated electronic medical record system all referring providers would refer patients to the specialty services of physical therapy and occupational therapy in a standardized format for all providers and everyone in the system will be able to see the referral and when the individual’s appointment is made.

d) **Conduct quality improvement projects:** Outpatient rehabilitation services manager/leadership will provide ongoing evaluation of the program. These personnel will identify barriers to access and create solutions to circumvent these obstacles. They will continually measure and analyze the difference between number of total referrals for the system and the number patients served to determine availability of services. In addition, they will evaluate the improvement that therapy services make on the individual’s served quality of life and adjust services as needed to best serve the population for optimal outcomes. Finally, further evaluation of the population served will be conducted to determine continual changes to the program to improve the overall health of the population through therapy services with increased access. Plan Do Study Act cycles will be implemented to continually evaluate process improvements throughout the project.
Unique community need identification numbers the project addresses:

- CN.2- Inadequate access to specialty care
- CN.6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN.11- High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including
  - Cancer
  - Diabetes
  - Obesity
  - Cardiovascular disease
  - Asthma
  - AIDS/HIV

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

Currently the Harris Health System Outpatient Rehabilitation Services department is serving medical home patients in two centrally located outpatient facilities. Additionally, current staffing is not adequate to meet the demand for specialty Physical and Occupational Therapy services. This project will enhance the ability to serve more patients, that is, improve access to these services, while at the same time improve health outcomes and quality of life for the patients served. By locating new clinics in underserved areas and adding additional staff this project will reduce barriers to accessing specialty therapy services and further integrating these services into the medical home model.

Related Category 3 Outcome Measure(s):

OD- 10 Quality of Life/Functional Status:

- IT-10.1 Quality of Life
  a. Demonstrate improvement in quality (QOL) scores, as measured by evidence based and validated assessment tool, for the target population. Patients will complete the Short Form Health Survey (SF-12) upon initial evaluation and upon discharge from Physical or Occupational Therapy to measure the patient’s perceived quality of life before and after therapy intervention. This tool is evidence based and validated for a wide range of diagnostic groups that are routinely seen in outpatient services.
  b. Data source: The SF- 12 was developed by the RAND Corporation as part of the multi-year Medical Outcomes Study to explain variations in patient outcomes. The SF- 12 is a multipurpose, 12 -item survey that measures eight domains of health: physical functioning, role limitations due to physical health, bodily pain, general health perceptions, vitality, social functioning, role limitations due to emotional problems, and mental health. It yields scale scores for each of these eight health domains, and two summary measures of physical and mental health: the Physical Component Summary (PCS) and Mental Component Summary (MCS). A copy of this form will be provided as needed.

Reasons/rationale for selecting the outcome measure:

Lack of access to specialty Physical and Occupational Therapy services results in decreased quality of life. Earlier intervention and improved access for acute neuro and
musculoskeletal deficiencies result in less impairment, improved quality of life, and ultimately decreased health care costs. The SF-12 will allow therapists to track patients’ self-reported perceived quality of life to help manage treatment programs and produce improved health outcomes.

This outcome measure was selected because it is able to be used on individuals from a wide range of age groups and treatment groups with a variety of diseases and conditions. In addition, this outcome measure is available in over 140 translations. This tool is evidence based and validated for a wide range of diagnostic groups that are routinely seen in outpatient services.

**Relationship to other Projects and Other Performing Providers Projects in the RHP:**

This project will work in conjunction with Harris Health System Casa de Amigos Same Day Access Clinic and Southwest Area Same Day Access Clinic. This project will support the expansion of primary care physician services projects by accommodating the likely rise in referrals to specialty Physical and Occupational therapy services in the increase in staffing levels.

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

**Plan for Learning Collaborative:**

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

**Project Valuation:**

This project will increase the capacity to provide outpatient physical and occupational therapy services to the underserved areas of Harris County, primarily low-income, uninsured and Medicaid populations. The expanded Outpatient Physical Therapy and Occupational Therapy (PT and OT) services will be targeted to populations who are at risk for impairments in activities of daily living resulting from a lack of access to specialty care. The project will improve access by providing an additional 12 PT and OT providers to the Rehabilitation Services department and by adding additional outpatient therapy treatment space near the referring clinics, facilitating an increase in the number of patients appointed per month by specialty Physical and Occupational Therapy services of 510 patients. The project will result in improved quality of life by persons served, measured by a standard health survey.
**Related Category 3 Outcome Measure(s):**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IMPROVE ACCESS TO SPECIALTY CARE: INCREASE ACCESS TO OUTPATIENT PHYSICAL AND OCCUPATIONAL THERAPY SPECIALTY SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Harris Health System</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>133355104.1.13</strong></td>
<td><strong>1.9.2</strong></td>
<td><strong>1.9.2 A-D)</strong></td>
<td><strong>133355104</strong></td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Quality of Life</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Measure(s):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>133355104.3.18</strong></td>
<td><strong>IT- 10.1</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Milestone 1</strong> [P-X2]: Project planning; engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Metric 1</strong> [P-X2.1]: Planning documentation</td>
<td>Goal: Produce a comprehensive implementation plan for onboarding additional FTE’s Data Source: project plan</td>
</tr>
<tr>
<td></td>
<td>Milestone 1 Estimated Incentive Payment: $3,504,622</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 2</strong> [I-22]: Increase the number of specialist providers for the high impact/most impacted medical specialties</td>
<td><strong>Metric 1</strong> [I-22.1]: Increase number of specialist providers</td>
<td>Baseline: 30.5 FTEs in DY2 Goal: Hire 5 specialists (5 Physical Therapists, total 5 therapists) Data Source: human resources reports</td>
</tr>
<tr>
<td></td>
<td>Milestone 2 Estimated Incentive Payment: $1,312,606</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 3</strong> [P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties</td>
<td><strong>Metric 1</strong> [P-2.1]: Training of staff and providers working in specialty care and medical specialty clinics</td>
<td>Baseline: 0 providers trained Goal: Train all specialty providers Data Source: Training curriculum and materials and Documentation of training attendance</td>
</tr>
<tr>
<td></td>
<td>Milestone 3 Estimated Incentive Payment: $1,312,607</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 4</strong> [I-22]: Increase the number of specialist providers for the high impact/most impacted medical specialties</td>
<td><strong>Metric 1</strong> [I-22.1]: Increase number of specialist providers</td>
<td>Baseline: 35.5 FTEs in DY3 Goal: Hire 5 specialists (3 Physical Therapists, and 2 Occupational Therapists, total 10 therapists by DY4) Data Source: human resources reports</td>
</tr>
<tr>
<td></td>
<td>Milestone 4 Estimated Incentive Payment: $1,972,075</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 5</strong> [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services</td>
<td><strong>Metric 1</strong> [I-23.1]: Documentation of increased number of unique patients. Demonstrate improvement over prior reporting period (baseline for DY3).</td>
<td>Baseline: 1,260 Goal: 422 additional new patients appointed per month. Data Source: EHR</td>
</tr>
<tr>
<td></td>
<td>Milestone 5 Estimated Incentive Payment: $1,085,949</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 6</strong> [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services</td>
<td><strong>Metric 1</strong> [I-23.1]: Documentation of increased number of unique patients. Demonstrate improvement over prior reporting period (baseline for DY3).</td>
<td>Baseline: 1,260 Goal: 422 additional new patients appointed per month. Data Source: EHR</td>
</tr>
<tr>
<td></td>
<td>Milestone 6 Estimated Incentive Payment: $1,085,949</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Regional Healthcare Partnership Plan**

Region 3

258
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 4 [I-23]:</strong> Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients. Demonstrate improvement over prior reporting period (baseline for DY2). Baseline: 1,040 patients appointed per month. Goal: 220 additional new patients appointed per month. Data Source: EHR. Milestone 4 Estimated Incentive Payment: $1,312,606</td>
<td></td>
<td>Milestone 6 Estimated Incentive Payment: $1,972,074</td>
<td>Milestone 9 [P-1]: Conduct a new gap assessment based on the community need. Metric 1 [P-1.1] Documentation of gap assessment. Goal: Improve access based on referral data and make changes to clinic model as indicated by new gap assessment. Data source: complete needs assessment report. Milestone 9 Estimated Incentive Payment: $1,085,949</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $3,504,622 | Year 3 Estimated Milestone Bundle Amount: $3,937,819 | Year 4 Estimated Milestone Bundle Amount: $3,944,149 | Year 5 Estimated Milestone Bundle Amount: $3,257,847 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $14,644,436
Project Option 1.1.1- Establish more primary care clinics: Casa de Amigos Same Day Access Clinic

Unique RHP Project ID: 133355104.1.14 / Pass 2
Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

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

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

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

Need for the project:
Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. For the Casa de Amigos health center, there were 107 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone.

Target Population:
Any patient seeking primary care within the system may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

Category 1 or 2 expected patient benefits:
Our goals are to see 1,000 completed visits in DY3; 10,000 in DY4; and 20,000 in DY5, for a total of 31,000 visits from DY3-DY5.

Category 3 outcomes:
IT 6.2- Other: Percent improvement over baseline of Patient Satisfaction scores. Our goal is to increase overall score by 0.5% over baseline in DY4 and by 1% over baseline in DY5. Project
Option 1.1.1- Establish more primary care clinics: Casa de Amigos Same Day Access Clinic

**Unique RHP Project ID:** 133355104.1.14 / Pass 2  
**Performing Provider Name/TPI:** Harris Health System / 133355104

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

A same day access clinic will ideally be located in or around the following zip code to meet the adult primary care demand surrounding the Casa de Amigos Health Center (Casa): 77009. The clinic will be approximately 3,000-4,000 square feet of leased space. The Facilities and Planning department at the Harris Health System has confirmed that such lease space is available in or around the target zip code. Harris Health System plans to add new providers and staff to operate the clinic for extended evening hours and weekend hours, in addition to regular weekday hours, based on demand. Point of Care lab testing will be available. If patients are in need of imaging or pharmacy services, they will be referred to the nearest health center that provides those services.

**Goal(s) and Relationship to Regional Goal(s):**
The goals of this project are to:
- Increase capacity for same day primary care through establishment of more accessible care locations across Harris County
- Increase access to same day primary care during extended hours and weekends

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

This project meets the following Region 3 goals:
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

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

**Challenges and how to address:**
General primary care capacity has been a challenge for the Harris Health System. The same day access clinic will provide same day access for Medical Home and non-Medical Home patients. A significant challenge for the Harris Health System has been adequate capacity to offer Medical Homes for patients who do not have a primary care provider. As patients are seen in the same day access clinic setting, this will continue to be a problem for those patients who need care for chronic conditions or other specialized care. To address these challenges we propose to direct...
patients with chronic conditions into the Medical Home setting at a Harris Health System health center or refer to other primary care settings, such as local FQHCs.

**5-Year Expected Outcome for Provider and Patients:**
Over the course of the 5-Year Waiver, Harris Health System expects to realize:
- Increased adult-focused primary care capacity through same day care clinics for primary care treatable conditions

**Starting Point/Baseline:**
For performance purposes, the baseline will be set at 0 visits since this is a new clinic that currently is not operational. We expect to see 1,000 visits in the first year of operations (DY3).

**Rationale:**
**Reasons for selecting the project option:**
Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health System health centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For the Casa de Amigos Health Center, there were 107 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. Casa de Amigos received 49 Ask My Nurse request per month for patients that needed same day appointments that could not be scheduled by the Patient Appointment Center. These numbers, however, do not capture the full volume of unmet demand due to the fact that some calls were dropped as patients were placed on hold and some patients who needed care did not attempt to obtain an appointment based on previous difficulties obtaining same day appointments. Based on 2012 data of incoming patient calls to the Patient Appointment Center, 4,627 unduplicated patients living near Casa de Amigos Health Center were unable to get an appointment.

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

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

**Milestones & Metrics:**
- Process Milestones and Metrics- P-1 (P-1.1); P-5 (P-5.1); P-X (P-X.1);
- Improvement Milestones and Metrics- I-12 (I-12.1)
Unique community need identification number the project addresses:
This project addresses the following community needs according to the community needs assessment:

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

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

Related Category 3 Outcome Measure(s):
OD-6 Patient Satisfaction
IT 6.2- Other: Percent improvement over baseline of Patient Satisfaction scores

Reasons/rationale for selecting the outcome measure(s):
The same day access clinic will increase capacity for primary care visits within the Harris Health System, which will enhance access and improve the patient’s experience in obtaining services. Patient satisfaction scores have been historically poor for health centers regarding timely access to care. The same day access clinic will offer an efficient venue that offers same day visits, affording patients the opportunity to seek care in a high-satisfaction setting that is appropriate for the level of care they need and more cost effective than other alternatives. IT-6.2 was specifically chosen as Harris Health will be using Press-Ganey (approved by HHSC) as the source for survey metrics and results. The survey chosen measures all aspects of a patient visit, and thus will give Harris Health System a comprehensive indication of how we are performing.

Relationship to other Projects and Other Performing Providers’ Projects in the RHP:
Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.
Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

Project Valuation: This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic’s capacity to provide primary care services, including laboratory point-of-care testing, along with timely referrals for specialty care, imaging and other needed services within the Harris Health System network. We expect to achieve optimum capacity and productivity by the end of DY5, ultimately resulting in 20,000 completed visits per year. We will refer new patients with chronic disease management needs to one of the NCQA certified medical home clinics that are operated by Harris Health. In addition, the availability of same day primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.
<table>
<thead>
<tr>
<th>133355104.1.14</th>
<th>1.1.1</th>
<th>N/A</th>
<th>EXPAND PRIMARY CARE CAPACITY- CASA DE AMIGOS SAME DAY ACCESS CLINIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harris Health System</td>
<td></td>
<td></td>
<td>133355104</td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td>133355104.3.19</td>
<td>IT-6.2</td>
<td><strong>Other</strong>: Percent improvement over baseline of patient satisfaction scores</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Outcome Measure(s):</strong></th>
<th><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</th>
<th><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</th>
<th><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</th>
<th><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Milestone 1 [P-X]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans | **Metric 1 [P-X.1]:** Planning documentation  
Goal: Produce a comprehensive implementation plan for the establishment of same day access clinic  
Data Source: Project plan | **Milestone 2 [P-1]:** Establish additional primary care clinics  
**Metric 1 [P-1.1]:** Number of additional clinics or expanded hours or space  
Baseline: 0 same day access clinics in target area in DY2  
Goal: Establish one same day access clinic  
Data Source: New primary care schedule  
Milestone 2 Estimated Incentive Payment *(maximum amount)*: $2,582,414 | **Milestone 5 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services  
**Metric 1 [I-12.1]:** Documentation of increased number of visits  
Goal: 10,000 completed visits in DY4  
Data Source: EHR  
Milestone 5 Estimated Incentive Payment *(maximum amount)*: $7,764,645 | **Milestone 6 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services  
**Metric 1 [I-12.1]:** Documentation of increased number of visits  
Goal: 20,000 completed visits in DY5, for a total of 31,000 completed visits in DY3-5  
Data Source: EHR  
Milestone 6 Estimated Incentive Payment *(maximum amount)*: $6,413,909 |
| **Milestone 1 Estimated Incentive Payment *(maximum amount)*: $6,996,473 | **Milestone 3 [P-5]:** Hire additional primary care providers and staff  
**Metric 1 [P-5.1]:** Documentation of increased number of providers and staff  
Baseline: 0 providers and staff hired in DY2  
Goal: Hire 3 Provider FTEs (MD and/or MLP)  
Data Source: Contract documentation  
Milestone 3 Estimated Incentive Payment *(maximum amount)*: $2,582,414 | **Milestone 4 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services  
**Metric 1 [I-12.1]:** Documentation of increased number of visits  
Goal: 10,000 completed visits in DY4  
Data Source: EHR | **Milestone 6 Estimated Incentive Payment *(maximum amount)*: $6,413,909 |
<table>
<thead>
<tr>
<th>I33355104.1.14</th>
<th>1.1.1</th>
<th>N/A</th>
<th><strong>EXPAND PRIMARY CARE CAPACITY- CASA DE AMIGOS SAME DAY ACCESS CLINIC</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Harris Health System</strong></td>
<td></td>
<td>133355104</td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td><strong>133355104.3.19</strong></td>
<td><strong>IT-6.2</strong></td>
<td>Other: Percent improvement over baseline of patient satisfaction scores</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
<tr>
<td>Care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1 [I-12.1]: Documentation of increased number of visits.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline: 0 visits in DY2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: 1,000 completed visits.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment (maximum amount):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$2,582,415</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Milestone Bundle Amount</strong>: (add incentive payments amounts from each milestone):</td>
<td><strong>Year 3 Estimated Milestone Bundle Amount</strong>: $7,747,243</td>
<td><strong>Year 4 Estimated Milestone Bundle Amount</strong>: $7,764,645</td>
<td><strong>Year 5 Estimated Milestone Bundle Amount</strong>: $6,413,909</td>
</tr>
<tr>
<td>$6,996,473</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add milestone bundle amounts over Years 2-5):</td>
<td><strong>$28,922,270</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Project Option 1.8.6 - The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours: Increase, Expand, and Enhance Oral Health Services: Expansion of Adult Dental Services

Unique RHP Project ID: 133355104.1.15 / Pass 2
Performing Provider Name/TPI: Harris Health System/133355104

Project Summary:

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

Volume Statistics - FY2012

<table>
<thead>
<tr>
<th>Hospital admissions</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>35,343</td>
<td>Self-Pay- 62.6%</td>
<td>Hispanic- 57.4%</td>
</tr>
<tr>
<td></td>
<td>Medicaid and CHIP- 23.4%</td>
<td>African American- 26.3%</td>
</tr>
<tr>
<td></td>
<td>Medicare- 8.6%</td>
<td>Caucasian- 9.2%</td>
</tr>
<tr>
<td></td>
<td>Other Funding- 3.6%</td>
<td>Asian- 4.8%</td>
</tr>
<tr>
<td></td>
<td>Commercial Insurance- 1.8%</td>
<td>Other- 2.2%</td>
</tr>
<tr>
<td>6,643</td>
<td></td>
<td>American Indian- 0.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>173,263</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient clinic visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,054,770</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Intervention(s):
This project will expand adult dental services by establishing additional sites and expanding services at current sites. Services will be added or expanded at 6 health centers.

Need for the project:
Health System offers adult dental services at 8 community health centers. A stand-alone dental center provides urgent care, oral surgery, and dentures. However, current access is not sufficient. Bad oral health care increases the risk of heart disease, diabetes and stroke.

Target Population:
Any adult patient within the system who seeks dental care may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

Category 1 or 2 expected patient benefits:
Our goals are to increase completed visits at new and existing dental clinic sites by 1,100 in DY3, 8,700 in DY4 and 16,250 in DY5 for a total of 26,050 completed visits by end of waiver program. DY5.

Category 3 outcomes:
IT-7.8: Our goal is to increase the percentage of patients with diabetes accessing dental services following referral by their medical provider. We will increase by 5% over baseline in DY4 and 7% in DY5. In a study conducted by United Concordia Dental and parent company Highmark Inc in 2012 showed that “periodontal treatment for individuals with diabetes resulted in a 33% decrease in hospitalizations per year and a 13% decrease in Physician visits per year resulting in significant cost savings.
Project Option 1.8.6 - The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours: Increase, Expand, and Enhance Oral Health Services: Expansion of Adult Dental Services

**Unique RHP Project ID:** 133355104.1.15 / Pass 2
**Performing Provider Name/TPI:** Harris Health System/133355104

**Project Description:**
*Harris Health System proposes to expand adult dental services by establishing additional sites and expanding services at current sites.*

Dental services will be added or expanded at 6 health centers. Currently the Harris Health System offers adult dental services at 8 community health centers. A stand-alone dental center provides urgent care, oral surgery, and dentures. We are one of the few public health systems in the nation that offers oral health services to its patient population.

Harris Health System proposes to establish additional adult-focused primary care centers to meet the demand that saturated existing Harris Health System health centers cannot meet. Current and new facilities will be assessed for dental services to include 1 FTE dentist in DY3 and 6 dentist FTEs in DY4.

**Goals:**

**Project Goals:**
- Expand adult oral health services at 5 existing and 1 new health centers.
- Increase number of adults receiving oral health services.

**Regional goals addressed with project:**
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
  - Vulnerable and underserved populations face numerous barriers to accessing oral health care. Access to oral care is critical for overall health for all stages of life. The impact of untreated oral health has been linked to diabetes, heart disease, and stroke. Additionally, poor oral health can affect appearance, self-esteem, and one’s ability to chew and digest food properly. This proposal will focus on areas of low-income families who may otherwise not have adequate access to oral health care.

**Challenges:**
- Harris Health System currently has a waitlist for adult oral health services.
- Though our current facilities have space restrictions to expand oral health services, existing sites will be modified to install additional Dental Chairs to expand access for adult oral health services and services will be added in 1 new health center.

**5-year expected outcome for Performing Provider and patients:**
By addressing the challenges for Harris Health System as performing provider, we expect to achieve the overarching goal of increasing access to oral health services in the underserved areas of Harris County.
Starting Point/Baseline:
In FY12 Harris Health System provided 67,144 oral health care visits. From January 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 30,632 unduplicated patients for oral health care. However, these numbers do not capture the full volume of unmet demand due to the fact that some calls were dropped as patients were placed on hold and some patients who needed care did not attempt to obtain an appointment based on previous difficulties obtaining same day appointments.

Rationale:
There are significant disparities in oral health care between some population groups, including, but not limited to, the uninsured, children, minorities, publically insured, elderly, and low income individuals. Improving access to these vulnerable populations is the first step in reducing disparities and improving oral health care.

Adequate oral health services are a vital and basic component for overall health. Health risks from lack of good dental care reach further than just cavities and gum disease. Bad oral health care increases the risk of heart disease, diabetes and stroke. By adding and expanding dental services to seven sites, we will be increasing access to oral health services for the underserved in Harris County, and thereby helping to reduce disparities.

Project Components:
This project option does not have required project components.

Milestones & Metrics:
Harris Health System has chosen project option 1.8.6: The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours to best fit the scope and goal of this project.
- Process Milestones and Metrics: P-4, P-4.1; P-X1, P-X1.1; P-X2, P-X2.1; P-X3, P-X3.1
- Improvement Milestones and Metrics: I-X1, I-X1.1

Unique Community Need Identification Numbers:
- CN.1: Inadequate access to primary care
- CN.4: Inadequate access to dental care
- CN.11: High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including: Cancer, Diabetes, Obesity, Cardiovascular disease, Asthma, AIDS/HIV

The scope and goals of this project specifically address three of the identified community needs from the regional needs assessment. The project focuses on CN.1, CN.4, and CN.11 by increasing access to oral health services. This aligns with CN.11 by addressing the importance of adequate access for our patients with chronic diseases.

How the project represents a new initiative for Performing Provider or significantly enhances an existing delivery system reform initiative:
There is limited access for oral health, particularly for the low-income, uninsured, and Medicaid populations. Oral health is vital in disease prevention. This project will allow Harris Health System to increase access to the underserved populations through expansion of services in existing and additional facilities. Treating cavities and other oral health problems has potential cost savings by preventing other chronic diseases, such as diabetes.
Related Category 3 Outcome Measure(s):  
OD-7 Oral Health

Improvement Target(s):
- IT-7.8 Chronic Disease Patients Accessing Dental Services  
Harris Health System plans to increase oral health access of our adult patients with diabetes following a referral from their provider. We will begin to measure and report in DY4.

Reasons/rationale for selecting the outcome measure(s):
We chose to measure the percentage of patients with diabetes who access our dental services following a referral. It is especially important that diabetic patients receive appropriate oral health services, as high blood sugar has been linked to tooth decay and gum disease. Gum disease is a risk factor for complications of diabetics and can put diabetics at a higher risk for additional gum problems. In an article published in the September 2002 issue of the Journal of the American Dental Association, “gum diseases may also make it more difficult for diabetics to control their blood sugar”. And in studies presented by Cigna Medical and Dental Plans at the 2009 International Association of Dental Research meeting in Miami, FL, they noted that for all individuals enrolled in their Medical and Dental Plan, diabetic patients who received periodontal treatment saw a reduction in the average cost just in the first year of about $1,418.

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

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

Project Valuation:
There is limited access for oral health, particularly for the low-income, uninsured, and Medicaid populations. Oral health is vital in disease prevention. Bad oral health care increases the risk of heart disease, diabetes and stroke. By adding and expanding dental services to six sites, we will be increasing access to oral health services for the underserved in Harris County, and thereby helping to reduce disparities. The expanded services in Harris Health clinics can ultimately address the routine dental care needs of over ten thousand patients, or an additional 26,050 cumulative visits. In a study conducted by United Concordia Dental and parent company Highmark Inc in 2012, it was stated that “periodontal treatment for individuals with diabetes was associated with a significant decrease in hospitalizations and physician visits, delivering annual savings of $1,814 in medical care per patient per year. Likewise the reduction in pharmacy costs averages $1,477 for diabetics who have gum disease and receive at least seven treatments per year”. Treating cavities and other oral health problems will assist in providing healthcare cost

Regional Healthcare Partnership Plan  
Region 3
savings by preventing or mitigating the effects of other chronic diseases with a specific focus on the diabetic population.

<table>
<thead>
<tr>
<th>Milestone 1 [P-X1]: Project planning</th>
<th>Milestone 2 [P-4]: Establish and expand additional dental care clinics.</th>
<th>Milestone 5 [I-X]: Increase number of adult patients who access Harris Health oral health services.</th>
<th>Milestone 7 [I-X]: Increase number of adult patients who access Harris Health oral health services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [P-X1.1]: Planning documentation</td>
<td>Metric 1 [P-4.1]: Number of additional clinics or expanded hours or space Baseline: Dental services at 8 sites Goal: Establish and Expand dental services in 1 additional health centers and 5 existing health centers Data Source: New dental schedule</td>
<td>Metric 1 [I-X.1]: Increase the number of adults accessing oral health services. Goal: 8,700 completed visits Data Source: EHR</td>
<td>Metric 1 [I-X.1]: Increase the number of adults accessing oral health services. Goal: 16,250 completed visits Data Source: EHR</td>
</tr>
<tr>
<td>Goal: Produce a comprehensive implementation plan for the establishment and expansion of dental clinics. Data Source: Project plan</td>
<td>Milestone 2 Estimated Incentive Payment (maximum amount): $2,353,005</td>
<td>Milestone 5 Estimated Incentive Payment (maximum amount): $3,537,209</td>
<td>Milestone 7 Estimated Incentive Payment (maximum amount): $5,843,722</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment (maximum amount): $6,365,521</td>
<td>Milestone 3 [P-X2]: Hire additional dental staff</td>
<td>Milestone 6 [P-X2]: Hire additional dental staff</td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-X2.2]: Documentation of increased number of dental staff Baseline: 19 FTE Dentist Goal: Hire 1 additional FTE Dentist Data Source: Contract documentation</td>
<td>Milestone 3 Estimated Incentive Payment (maximum amount): $2,353,005</td>
<td>Metric 1 [P-X2.2]: Documentation of increased number of dental staff Baseline: 20 FTE Dentist from DY3 Goal: Hire 6 additional FTE Dentists Data Source: Contract documentation</td>
<td></td>
</tr>
<tr>
<td>Milestone 4 [P-X3]: Establish baseline number of completed visits Metric 1 [P-X3.1]: Documentation of</td>
<td>Milestone 4 Estimated Incentive Payment (maximum amount): $2,353,005</td>
<td>Milestone 6 Estimated Incentive Payment (maximum amount): $3,537,210</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>133355104.1.15</td>
<td>1.8.6</td>
<td>N/A</td>
<td>Increase, Expand, and Enhance Oral Health Services: Expansion of Adult Dental Services</td>
</tr>
<tr>
<td>----------------</td>
<td>-------</td>
<td>-----</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Harris Health System</strong></td>
<td>133355104</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td><strong>133355104.3.20</strong></td>
<td><strong>IT-7.8</strong></td>
<td><strong>IT-7.8 Chronic Disease Patients Accessing Dental Services</strong></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>completed visits</td>
<td>completed visits</td>
<td>completed visits</td>
<td>completed visits</td>
</tr>
<tr>
<td>Baseline: 0 completed visits in DY2</td>
<td>Baseline: 0 completed visits in DY2</td>
<td>Baseline: 0 completed visits in DY2</td>
<td>Baseline: 0 completed visits in DY2</td>
</tr>
<tr>
<td>Goal: 1,100 completed visits</td>
<td>Goal: 1,100 completed visits</td>
<td>Goal: 1,100 completed visits</td>
<td>Goal: 1,100 completed visits</td>
</tr>
<tr>
<td>Data Source: EHR</td>
<td>Data Source: EHR</td>
<td>Data Source: EHR</td>
<td>Data Source: EHR</td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: ($6,365,521)</td>
<td>Year 3 Estimated Milestone Bundle Amount: $7,059,016</td>
<td>Year 4 Estimated Milestone Bundle Amount: $7,074,419</td>
<td>Year 5 Estimated Milestone Bundle Amount: $5,843,722</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add milestone bundle amounts over Years 2-5): $26,342,678</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add milestone bundle amounts over Years 2-5): $26,342,678</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add milestone bundle amounts over Years 2-5): $26,342,678</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add milestone bundle amounts over Years 2-5): $26,342,678</td>
</tr>
</tbody>
</table>
Harris County Hospital District Ben Taub General Hospital
Pass 3
**Project Option-1.1.4 “Other”: Implement other evidence-based project to expand primary care capacity: House Calls Program**

**Unique RHP Project Identification Number:** 133355104.1.16/ Pass 3  
**Performing Provider Name/TPI:** Harris Health System / 133355104

**Project Summary:**

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

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

**Intervention(s):**
This project will expand the House Calls Program in order to improve access, maximize independence, provide the right care in the right setting, and realize cost savings by providing comprehensive, coordinated, multidisciplinary primary care at home to a population of patients that are homebound or have difficulties getting to clinic visits.

**Need for the project:**
Many Texans with multiple chronic illnesses are housebound, too ill or disabled to easily visit their physician’s office. Instead, they go to the Emergency Center (EC) or hospital, often by ambulance ($600/ Round Trip), for routine care.

**Target Population:**
The target population for these goals includes any patient who is homebound or has extreme difficulties getting to clinic visits due to their health status. (Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

**Category 1 or 2 expected patient benefits:**
Our goal is to increase number of homebound patients seen to a total of 1,000 patients in DY5.

**Category 3 outcomes:**
IT-9.2: Our goal is to reduce inappropriate EC utilization from patients seen by these House Calls teams. In DY4, we expect to see a 5% decrease, and in DY5 a 10% decrease in inappropriate ED use by target population.
Project Option-1.1.4 “Other”: Implement other evidence-based project to expand primary care capacity: House Calls Program

**Unique RHP Project Identification Number:** 13335104.1.16/ Pass 3  
**Performing Provider Name/TPI:** Harris Health System / 133355104  
**Project Description:**

_Harris Health System proposes to expand the House Calls Program in order to improve access, maximize independence, and realize cost savings by providing comprehensive, coordinated, multidisciplinary primary care at home to a population of patients that are homebound or have difficulties getting to clinic visits._

Many Texans with multiple chronic illnesses (heart disease, strokes, dementia) are housebound, too ill or disabled to easily visit their physician’s office for needed care. Instead, they go to the Emergency Center (EC) or hospital, often by ambulance ($600/ Round Trip), for routine care. These patients make up a small percentage of the patient population, but the cost to treat them is disproportionately high. House calls are our proposed solution to help these high-cost, debilitated, home-limited patients get access to care. In Harris Health, the average EC visit cost is $832, so avoiding one EC visit provides a huge cost savings. Savings are even greater for avoided hospitalizations ($12,000/admission). Most importantly, the continuity and quality of care and patient and family satisfaction is markedly increased with house calls. Harris County, the population served by Harris Health System, will be divided into quadrants and established teams distributed through these quadrants to provide home care. Homebound patient’s access to care requires ambulance transport and often the EC is used for primary care. We will use house calls to increase access to primary care throughout Harris County by removing obstacles to it and bring primary care to the patient. The geographical challenges of the region will be addressed by a logistics approach using regional cohorting, and the house calls model will create patient-centered, coordinated primary care delivery that improves patient satisfaction and health outcomes, reduces unnecessary services, and builds on the accomplishments of our existing health care system. Care coordination services, across all treatment settings, will be furnished by a physician/nurse practitioner-directed team of health care professionals who are available 24/7 (typically by telephone) to carry out individualized plans of care[1].

We will grow our existing program (0.6 MD FTE and 0.9 NP FTE following 180 patients) to create two full multidisciplinary teams (each team 1.5 MD and 3 NP plus SW, Pharm, etc.); each of which will ultimately have a census of 500 patients, make 2,500 house calls per year, have an active call system to triage and treat to prevent unneeded EC visits and subsequent hospital admissions, and attain an estimable level of patient and caregiver satisfaction. We conservatively estimate from our current experience and the literature that this house calls team will prevent 1 EC visit per year per enrolled patient, 5 round trip non-emergent ambulance rides for routine care per patient per year, 0.3 hospitalizations per year per enrolled patient, and one emergent ambulance ride per patient per year. Even with these conservative estimates, the prevention of these expensive episodes gives significant value of the house calls program. The cumulative impact will be 14,000-15,000 fewer ambulance rides, 2,800 fewer EC visits, 1,000 fewer admissions which adds up to $24 million in cost avoidance and almost 18 million in realized savings.

There will also be a significant training mission to fulfill unmet needs. Two thirds of physicians treating patients with multiple chronic conditions believe that their training did not
adequately prepare them to coordinate in-home and community health services. Even fewer have significant experience performing house calls; many have never performed a single house call[2]. While these comments are applicable to physicians (and trainees), they are also broadly applicable to pharmacists, nurse practitioners and all the other members of the health care team managing these complicated house call patients[2]. We will address this issue with technology and training. Active learners will include trainees at Baylor College of Medicine as well as Geriatrics fellows in the Baylor Geriatrics fellowship program and pharmacy students at University of Houston School of Pharmacy (ongoing programs). Trainees from the University of Texas Health Science Center-Houston will also be integrated into the project as part of the teams.

Patients will retain freedom of choice and the ability to opt out of the house calls program and enrollment in the program does not force them to forego any existing benefit. Improved technologies and innovation are revolutionizing house calls. We already use point-of-care devices to get blood tests at the bedside. Monitoring and more sophisticated assessment can be performed using various technologies in the patient’s home[3], but that is not the focus of this proposal.

Goals and Relationship to Regional Goals:

Project Goals:
- Improve Access
- Maximize independence
- Realize cost savings

The target population for these goals is patients who are homebound or have extreme difficulties getting to clinic visits due to their health status. Right now their access to care requires ambulance transport and often the EC is used for primary care. We will use house calls to improve access to primary care by removing obstacles and bringing the primary care provider to the patient. We will increase independence by working to modify the home environment and realize cost savings by decreasing ambulance use, optimizing EC use, and hospitalizations. This project meets the following regional goals:

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

Challenges:
- Geography: The region we hope to serve is over 1,700 square miles. Without logistic support, the time spent driving from one visit to the next can be frustrating and inefficient. We will utilize computer based models to optimize the scheduling of visits to minimize miles driven and time spent out of patient’s homes.
- Insufficient physician training: Professional training in providing care in patient homes is almost non-existent. We will grow our learning relationships to involve medical students.
and residents (Baylor College of Medicine and University of Texas Health Science Center-Houston), pharmacy students (University of Houston), and nursing students (University of St. Thomas). We will also augment the experiences of Geriatric fellows to train our next wave of providers.

- Personal safety concerns: Going alone to some of the homes can be harrowing. We plan to diminish risk by having more than one clinician go to the sites.

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

Our present house calls team is very modest, delivering care to 180 housebound patients. At the end of this proposal, two interdisciplinary teams including physicians, nurse practitioners, social workers, pharmacists, dietitians, and a support team will be managing 1,000 patients in their homes and making 5,000 house calls in the year.

**Starting Point/Baseline:**

Harris Health System currently has an active house call team headquartered at Quentin Mease Hospital consisting of 2 part-time physicians (total 0.6 FTE) and 2 part-time nurse practitioners (total 0.9 FTE) that cares for 180 housebound patients for a total of 900 house calls in 12 months ending 12/11. Currently, there is capability to perform point of care laboratory studies with the newest technology, (ISTAT-1) and the team is consistently writing progress notes into electronic medical record (EPIC) using the internet.

**Rationale:**

It has been proven that house call based primary care for home-bound individuals works [4]. For example, the Virginia Commonwealth Medical Center house calls program reduced hospital costs by 60% [5]. Call Doctor Medical Group in San Diego reduced ER visits by 59%[4]. In New York, Mount Sinai Visiting Doctors reduced hospitalizations by 66% [6].

In addition to Home-based programs’ potential to save on the most expensive patients, these programs decrease mortality of frail elderly[7] and prevent nursing home placement. House calls slow the progression of disability[8], improve medication management [9] and decrease medication- associated adverse events[1]. House calls identify new medical and safety problems before they cause clinical harm [10], decrease caregiver burden and enhance quality of life for patient and caregiver [1]. House calls improve end-of-life care for patients and have proven to increase physician satisfaction as well[1].

In 2003, the U.S. Department of Transportation reported [11] that, “More than 3.5 million people in this country never leave their homes.” While 20% of those over 85 are housebound [12], by calculation almost 1% of those between 25 and 65 also do not leave their homes. Therefore, there is a huge potential population from which to target [13]. Because of our focus and mission, other priority patient populations will be targeted including frequent EC users, especially those using “911” transportation, and those referred from the inpatient units, at high risk for readmission after discharge [9]. Thus, a significant number of our new patient house calls will be “immediately” post-discharge visits[9].

**Project Components:**

This project option does not include any required core project components. However, we will increase our capacity to provide primary care to more individuals, by: a) adding additional primary care providers, b) adding social workers/case managers, c) adding a logistics expert, and
d) forming multidisciplinary care teams. Additionally, we will use performance improvement principles to modify the selection criteria to increase the efficacy of the house calls intervention. We will compare the resource utilization for the three months prior to enrollment in the house calls program to the months after the house calls begin to start to assess the effects of this effort on resource utilization.

**Milestones and Metrics:**

**Process:**
P-5 Milestone: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers  
P-5.1 Metric: Documentation of increased number of providers and staff and/or clinic sites.  
P-X1 Milestone: Establish care management protocols.  
P-X1.1 Metric: Documentation of protocols.  
P-X2 Milestone: Establish baseline of housebound patients.  
P-X2.1 Metric: Establish new baseline from current patients seen  
P-X3 Milestone: Establish central call center to provide logistic support to house calls team.  
P-X3.1 Metric: Documentation of implementation.  

**Improvement:**
I-X1 Recruit homebound patients to house calls program.  
I-X1.1 Increase number of homebound patients seen  
I-11 Milestone: Patient satisfaction with primary care services.  
I-11.5 Metric: Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores. Demonstrate improvement over prior reporting period.

**Unique community need identification numbers the project addresses:**
CN.1-Inadequate access to primary care; CN.6-Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly; CN.7-Insufficient access to care coordination practice management and integrated care treatment programs; CN.8-High rates of inappropriate emergency department utilization; CN.9-High rates of preventable hospital readmissions; CN.10-High rates of preventable hospital admissions; and CN.11-High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This project will significantly enhance an already successful program by increasing it size, reach and scope of patient. Our 180 patients are mostly elderly and live within Beltway 8, but there are unmet needs in all adult age groups throughout Harris County including rural areas. Additionally, the multidisciplinary team is critical to the best outcomes for the patients and that is less available for the present House Calls program. With the goal to ultimately provide 2,000 of the most challenging patients with improved care that will more closely meet their needs and at a reduced cost, this project will greatly enhance the care delivery in Harris County.

**Related Category 3 Outcome Measures:**
OD-9  
IT-9.2: ED Appropriate Utilization
Reasons/rationale for selecting the outcome measures: This particular project has chosen to decrease inappropriate utilization of the EC by house calls patients seen. Because of transportation and logistics challenges, many homebound patients are using the EC as their source of primary care, the wrong care in the wrong (and most expensive) setting. By providing continuity of care in these patients’ homes, we will reserve the EC for appropriate use. With 24 hour phone access and (limited) capacity for urgent visits for heart failure and COPD exacerbations, even some otherwise “appropriate” use may be curtailed.

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

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

Project Valuation: This project will expand the House Calls Program in order to improve access, maximize independence, and realize cost savings by providing comprehensive, coordinated, multidisciplinary primary care at home to a population of patients that are homebound or have difficulties getting to clinic visits. The geographical challenges of the region will be addressed by a logistics approach using regional cohorting, and the house calls model will create patient-centered, coordinated primary care delivery that improves patient satisfaction and health outcomes, reduces unnecessary services, and builds on the accomplishments of our existing health care system. The present house calls team is very modest, delivering care to 180 housebound patients. By the end of the demonstration period, the interdisciplinary teams including physicians, nurse practitioners, social workers, pharmacists, dietitians, and support team will manage 1,000 patients in their homes and make approximately 5,000 house calls in the year. The cumulative impact will be several thousand fewer ambulance rides, fewer EC visits, 1,000 fewer admissions, resulting in millions of dollars in cost avoidance and realized savings.
**“Other”: Implement other evidence-based project to expand primary care capacity: House Calls Program**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>133355104.3.21</th>
<th>IT-9.2</th>
<th>ED Appropriate Utilization</th>
</tr>
</thead>
</table>

**Year 2** (10/1/2012 – 9/30/2013)

- **Milestone 1 [P-5]:** Train/hire additional primary care providers and staff
  - **Metric 1 [P-5.1]:** Documentation of increased number of providers and staff
    - Baseline: Current team consisting of 0.6 MD FTEs and 0.9 NP FTEs
    - Goal: Hire 0.9 MD FTEs and 2.1 NP FTEs to complete 1 team
    - Data Source: Hospital or other
    - Performing Provider report, policy, contract or other documentation
  - **Milestone 4 Estimated Incentive Payment:** $1,077,618

- **Milestone 2 [P-X1]:** Establish care management protocols.
  - **Metric 1 [P-X1.1]:** Documentation of protocols.
    - Baseline: None presently used
    - Goal: Establish care management protocols
    - Data Source: Protocols book
  - **Milestone 2 Estimated Incentive Payment:** $643,258

**Year 3** (10/1/2013 – 9/30/2014)

- **Milestone 4 [P-X3]:** Establish central call center to provide logistic support to house calls team.
  - **Metric 1 [P-X3.1]:** Documentation of implementation.
    - Goal: Hire 1.0 FTE RN for logistics support
    - Data source: Hiring records

- **Milestone 5 [P-5]:** Train/hire additional primary care providers and staff
  - **Metric 1 [P-5.1]:** Documentation of increased number of providers and staff
    - Baseline: Currently one team consisting of 1.5 MD FTEs and 3 NP FTEs
    - Goal: Hire 0.5 MD FTEs and 1.5 NP FTEs for a total of 1.5 teams
    - Data Source: Hospital or other
    - Performing Provider report, policy, contract or other documentation
  - **Milestone 5 Estimated Incentive Payment:** $1,656,901

**Year 4** (10/1/2014 – 9/30/2015)

- **Milestone 7 [P-5]:** Train/hire additional primary care providers and staff
  - **Metric 1 [P-5.1]:** Documentation of increased number of providers and staff
    - Baseline: Currently one and a half teams consisting of 2.0 MD FTEs and 4.5 NP FTEs each
    - Goal: Hire additional 1.0 MD FTEs and 1.5 NP FTEs
    - Data Source: Hospital or other
    - Performing Provider report, policy, contract or other documentation
  - **Milestone 7 Estimated Incentive Payment:** $1,656,901

- **Milestone 8 [I-X1]:** Recruit homebound patients to house calls program.
  - **Metric 1 [I-X1.1]:** Increase number of homebound patients seen
    - Goal: 820 patients above baseline (total of 1000 patients seen in DY5)
  - **Milestone 8 Estimated Incentive Payment:** $2,740,881

**Year 5** (10/1/2015 – 9/30/2016)

- **Milestone 10 [I-X1]:** Recruit homebound patients to house calls program.
  - **Metric 1 [I-X1.1]:** Increase number of homebound patients seen
    - Goal: 670 patients above baseline (total of 850 patients seen in DY4)
  - **Milestone 10 Estimated Incentive Payment:** $2,740,881
## “Other”: Implement other evidence-based project to expand primary care capacity: House Calls Program

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s)</th>
<th>133355104.3.21</th>
<th>IT-9.2</th>
<th>ED Appropriate Utilization</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment:</strong> $643,259</td>
<td><strong>Milestone 5</strong> Estimated Incentive Payment: $1,077,618</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 3** [P-X2]: Establish baseline of housebound patients.

**Metric 1** [P-X2.1] Establish new baseline from current patients seen
Baseline: 180 pts enrolled with current team
Goal: Census of 350 pts/team for 1 teams
Data Source: Internal Rosters

Milestone 3 Estimated Incentive Payment: $643,258

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $1,929,775</th>
<th>Year 3 Estimated Milestone Bundle Amount: $3,232,854</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 6</strong> [I-X1]: Recruit homebound patients to house calls program.</td>
<td></td>
</tr>
</tbody>
</table>

**Metric 1**[I-X1.1]: Increase number of homebound patients seen
Goal: 442 patients above baseline (total of 620 patients seen in DY3)
Data Source: Internal Rosters

Milestone 6 Estimated Incentive Payment: $1,077,618

<table>
<thead>
<tr>
<th><strong>Milestone 6</strong> Estimated Incentive Payment: $1,077,618</th>
<th>Year 4 Estimated Milestone Bundle Amount: $3,313,802</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 5 Estimated Milestone Bundle Amount: $2,740,881</strong></td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add milestone bundle amounts over DYs 2-5): $11,217,312</td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan
Region 3
Project Option 1.8.6- The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours: Expansion of Pediatric Dental Services

**Unique ID #:** 133355104.1.17/Pass 3  
**Performing Provider/TPI:** Harris Health System/133355104

**Project Summary:**

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

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

**Intervention(s):**
This project will address the growing need for pediatric oral health services by implementing these services across three facilities within our system.

**Need for the project:**
Currently, Harris Health System only offers adult oral health care at some of our centers. In fiscal year 2011, fewer than half of the 3.5 million Texas children eligible for dental services through Medicaid received preventive dental treatments. More than 1.38 million children did not receive any dental treatments at all.

**Target Population:**
Any pediatric patient within the system who seeks dental care may benefit from this project. Data from FY2012 shows that 60% of all pediatric visits in Harris Health System were funded.

**Category 1 or 2 expected patient benefits:**
Our goal is to increase the number of children accessing dental services. As this is a new service our baseline for patient volume will be established in DY3. Our volume predictions are 2,400 visits for DY3, 8,400 visits for DY4, and 9,700 visits for DY5 for a cumulative total of 20,500 visits. We are estimating 2.5 visits per patient per year, with a total 960 unduplicated patients in DY2, 3,360 unduplicated patients in DY4, and 3,880 unduplicated patients in DY5.
Category 3 outcomes:

IT-7.1: Our goal is to increase the number of children age 6-9 with a dental sealant on a permanent first molar tooth. By DY4 we will increase by 20% from baseline of children in this age category receiving a dental sealant and by 30% of baseline in DY5.

IT-7.4: Our goal is to increase the percentage of children, age 6mos-20 years, who received a fluoride varnish application. In DY4 we will increase by 30% from baseline of children receiving fluoride application and by 50% of baseline in DY5.

IT-7.6: Our goal is to decrease the percentage of children of record with urgent dental care needs. In DY4 we will reduce by 5% of DY3 and in DY5 we will reduce by 10% of DY3.
Project Option 1.8.6- The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours: Expansion of Pediatric Dental Services

Unique ID #: 133355104.1.17/Pass 3
Performing Provider/TPI: Harris Health System/133355104

Project Description

Harris Health System plans to address the growing need for pediatric oral health services by implementing these services across three facilities within our system. Currently, Harris Health System only offers adult oral health care at some of our centers. Harris Health System is one of the few public health systems in the nation that offers oral health services to its patient population. The scope of this project is to increase access to pediatric oral health services in areas of high need in the community, specifically to serve zip codes 77012, 77099, 77093 and their surrounding areas.

Project Goals:

• Increase pediatric oral health workforce by expanding services to the pediatric and adolescent patient population. Harris Health System proposes to expand pediatric dental FTE’s to 3.0.
• Establish pediatric and adolescent oral health services/clinics at three sites.
• Increase number of children and adolescents who will utilize the oral health care system.

Regional goals addressed with project:

• Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
  o Oral health services are essential in preventing gum disease and cavities, which have been linked to other diseases such as diabetes and heart stroke. Access to oral health services is especially important for children and adolescents, since dental problems may affect quality of life and ability to succeed. Children from lower-income families often do not receive timely treatment for tooth decay, and they are more likely to suffer from chronic conditions (National Center for Chronic Disease Prevention and Health Promotion). Harris Health System will focus on underserved areas of Harris County.

• Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
  o Providing adequate access to preventive oral health services for children and adolescents at Harris Health System will improve health care outcomes and increase patient satisfaction.
The following challenges/issues are faced by Harris Health System as the performing provider for this project:

- Harris Health System currently does not offer pediatric and adolescent oral health services. The addition of these services will be a new challenge. Currently, there are no existing pediatric and adolescent oral health services offered at Harris Health System. This poses a challenge because we will be initiating a new pediatric service line. However, the system does have experience in operating a dental clinic with its current facility for adults.

- There are current space constraints to offer this service within our system. Our current sites are not built or equipped for pediatric oral health services; therefore, Harris Health will need to modify space available in order to satisfy the proposed service expansion.

5-year expected outcome for Performing Provider and patients:
Harris Health System’s primary goal with this project is to increase access to appropriate levels of pediatric and adolescent oral health services in areas of high need. We plan to establish clinics that will increase the overall rate of annual dental visits for children and adolescents by increasing access to providers in these areas of high pediatric volumes. Upon implementation of these services, the proportion of children and adolescents who will utilize the oral health care system will increase, which increases preventive services and has the potential to decrease more costly chronic diseases in the future.

Starting Point/Baseline
Harris Health does not currently provide pediatric and adolescent oral health services at any of our sites; therefore, our baselines for patients and FTEs will be set at 0. In FY12, the system saw 53,359 unduplicated pediatric patients, which will guide us for expected volume. Of those 53,359 patients in FY12, 60% were funded.

Rationale
Many children have unmet dental needs. Dental and oral disease have been linked to numerous conditions, including, ear and sinus infections, weakened immune systems, diabetes, heart and lung disease, and other serious health conditions (Oral Health in America: A Report of the Surgeon General, 2000). In youth, untreated caries can adversely affect speech, nutrition, growth and function, social development, and quality of life. Children with dental-related problems are estimated to miss more than 51 million hours of school each year, and research an association between poor oral health and poor school performance (Oral Health in America). Yet, oral diseases are largely preventable.

In fiscal year 2011, fewer than half of the 3.5 million Texas children eligible for dental services through Medicaid received preventive dental treatments. More than 1.38 million children did not receive any dental treatments at all. Such treatments include teeth cleanings, fluoride treatments, and sealants to prevent cavities. Compared to other States, Texas has lower proportions of children with teeth in excellent or very good condition.

Although oral health in Texas has improved over the past several decades, there is a disproportionate utilization of access to dental care by income, race/ethnicity, and health insurance status. (NHANES, 1999-2004) Tooth decay is the most chronic childhood disease and is five times more common than asthma. Research shows that minority children living in poverty are
most likely to experience these problems. (Oral Health in Texas, 2008) This same group tends to have fewer sealants, more cavities, and the most advanced cases of oral disease. In a January 2013 report from the Pew Center on the States, Texas received a D on protecting its youth from tooth decay earning a score of 3 out of a possible 11 points.

In addition to reduced access to care for youth in poverty, the overall supply of pediatric dentists is not comparable to the demand. Although Medicaid and CHIP cover dental care, insurance coverage does not necessarily translate into access to care. For example, children with Medicaid and CHIP may not be able to obtain dental care if there are no dentists in their community that are accepting Medicaid or the parents do not realize the importance of oral health care. Dentists participation in Medicaid is low due to the low payment rates as well as administrative process. Harris Health System will address this significant disparity in oral health services for children and adolescents by adding oral health services at facilities in areas with high numbers of low-income minorities as well as educating parents at all points of contact on the importance of routine oral care.

Through its Healthy People 2020 Initiative, the federal government has set several national goals to improve the oral health of children and youth. Among the goals related to children and adolescent are to increase the proportion of low-income youth who had preventive dental service in the past twelve months, reduce the proportion of youth with a dental caries in their permanent teeth, and reduce the proportion of youth with untreated dental decay.

Adequate oral health services are vital for the overall health of children and adolescents. Inadequate oral health can lead to more serious issues that include physical, mental, economic and social adverse effects. By providing oral health services to one of the most vulnerable populations at their early stages of life will improve the overall health of Harris County children and adolescents.

**Project Components:**
This project option does not include any required core components. However, Harris Health System will monitor quality through continuous improvement measurement. To improve efficiencies and reduce redundancies, we will monitor consistency of workflows between sites. Additionally, we plan to integrate pediatric dental health records into Harris Health’s EMR to enhance efforts to improve quality of care and quality assurance in the delivery of dental care.

**Milestones and metrics:**
Harris Health System has chosen project option 1.8.6: The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours to best fit the scope and goal of this project.

Process Milestones and Metrics: P-4, P-4.1; P-7.1; P-X1, P-X1.1; P-X2.1 Improvement Milestones and Metrics: I-14, I-14.1
Unique Community Need Identification Numbers:

- CN.1- Inadequate access to primary care
- CN.4- Inadequate access to dental care
- CN.6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly

The project focuses on CN.1, CN.4, and CN.6 by increasing access for pediatric and adolescent patients to oral health services. This aligns with CN.6 by addressing the importance of adequate access and dental treatments for children and potential long term benefits for overall health.

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

There is limited access for pediatric oral health, particularly for the low-income, uninsured, and Medicaid populations. Oral health is vital in disease prevention, and while preventive oral healthcare for children has grown within the past years, oral health problems continue to be an issue for children and adolescents, particularly minorities and low-income children. This project will allow Harris Health System to create a footprint by increasing the number of pediatric dentists in areas of high need. Treating cavities and other oral health problems at an early age has potential cost savings by preventing other chronic diseases that may come later in life.

Related Category 3 Outcome Measures:
OD-7 Oral Health

Stand-Alone Measures:
-IT-7.6 Urgent Dental Care Needs: Percentage of children with urgent dental care needs

Reasons/rationale for selecting the outcome measure:
Harris Health System hopes to establish a dental home for children to provide regular access to dental care. Harris Health system will measure and decrease the percentage of children of record with urgent dental care needs. We will begin to measure and report in DY3 and decrease in DY4 and DY5.

Non-Stand-Alone Measures:
-IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth

Reasons/rationale for selecting the outcome measure:
By establishing a dental home we are increasing access to regular dental care. Harris Health system will measure and increase the percentage of children receiving a dental sealant. We will begin to measure and report in DY3 and decrease in DY4 and DY5.
Reasons/rationale for selecting the outcome measure:
This measure focuses on measuring one of the goals for oral health improvement for our targeted population. This is an improvement measure that is important in preventive care and reducing the number of cavities in children. Harris Health System will begin to measure and report in DY3 and increase in DY4 and DY5.

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

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

Project Valuation: The goal is to increase the number of children accessing dental services. Currently, Harris Health System only offers adult oral health care at some of our centers. Oral health services are essential in preventing gum disease and cavities, which have been linked to other diseases such as diabetes and heart stroke. Access to oral health services is especially important for children and adolescents, since dental problems may affect quality of life and ability to succeed. Children from lower-income families often do not receive timely treatment for tooth decay, and they are more likely to suffer from chronic conditions (National Center for Chronic Disease Prevention and Health Promotion). Treating cavities and other oral health problems at an early age has potential cost savings by preventing other chronic diseases that may come later in life. Through this project, we estimate 20,500 visits. This is a direct increase in access for pediatric oral health, as this service is not currently offered at Harris Health System.
### The Expansion of Existing Dental Clinics, the Establishment of Additional Dental Clinics, or the Expansion of Dental Clinic Hours: Expansion of Pediatric Dental Services

**Harris Health System**

<table>
<thead>
<tr>
<th>Related Category</th>
<th>Outcome Measure(s):</th>
<th>Metric</th>
<th>Baseline</th>
<th>Goal</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 3</td>
<td>133355104.3.31, 133355104.3.23, 133355104.3.32</td>
<td>IT-7.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3</td>
<td>133355104.3.23</td>
<td>IT-7.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3</td>
<td>133355104.3.32</td>
<td>IT-7.6</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Outcome Measure(s):**
- **Dental Sealant:** Percentage of children age 6-9 with a dental sealant on a permanent first molar within the measurement period.
- **Topical Fluoride application**
- **Urgent Dental Care Need:** Percentage of children with urgent dental care needs.

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1 [P-X1]:** Identify gaps in services and service needs.

**Metric 1 [P-X1.1]:** Conduct gap assessment to identify community need for new site.
- **Baseline:** Comprehensive report that addresses needs for pediatric oral health in community.
- **Goal:** Identify location for new sites.
- **Data Source:** Needs assessment.

**Milestone 1 Estimated Incentive Payment (maximum amount):** $4,089,774

**Milestone 2 [P-X2]:** Staffing for pediatric dental services.

**Metric 1 [P-X2.1]:** Hire and train staff to operate and manage projects selected.
- **Baseline:** 0
- **Goal:** 3 FTEs Dentist, 1 FTE Dental Hygienist.
- **Data Source:** Human Resources documentation.

**Milestone 2 Estimated Incentive Payment:** $1,389,762

**Milestone 3 [P-4]:** Establish additional dental care clinics.

**Metric 1 [P-4.1]:** Number of additional clinics and existing available space for pediatric dental clinic.
- **Baseline:** 0
- **Goal:** Add dental services at 3 sites.
- **Data Source:** Provider templates, EMR.

**Milestone 3 Estimated Incentive Payment:** $1,389,762

**Milestone 4 [I-14]:** Increase number of special population members that access dental services.

**Metric 1 [I-14.1]:** Increasing the number of children accessing dental services.
- **Baseline:** 2,400 visits
- **Goal:** 8,400 visits
- **Data Source:** EHR.

**Milestone 4 Estimated Incentive Payment:** $5,696,941

**Milestone 5 [I-14]:** Increase number of special population members that access dental services.

**Metric 1 [I-14.1]:** Increasing the number of children accessing dental services.
- **Baseline:** 2,400 visits
- **Goal:** 9,700 visits
- **Data Source:** EHR.

**Milestone 5 Estimated Incentive Payment:** $4,696,712
<table>
<thead>
<tr>
<th>133355104.1.17</th>
<th>1.8.6</th>
<th>N/A</th>
<th><strong>THE EXPANSION OF EXISTING DENTAL CLINICS, THE ESTABLISHMENT OF ADDITIONAL DENTAL CLINICS, OR THE EXPANSION OF DENTAL CLINIC HOURS: EXPANSION OF PEDIATRIC DENTAL SERVICES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Harris Health System</strong></td>
<td><strong>133355104</strong></td>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s):</strong></td>
</tr>
<tr>
<td><strong>133355104.3.31</strong></td>
<td><strong>IT-7.1</strong></td>
<td><strong>Dental Sealant:</strong> Percentage of children age 6-9 with a dental sealant on a permanent first molar within the measurement period.</td>
<td></td>
</tr>
<tr>
<td><strong>133355104.3.23</strong></td>
<td><strong>IT-7.4</strong></td>
<td><strong>Topical Fluoride application</strong></td>
<td></td>
</tr>
<tr>
<td><strong>133355104.3.32</strong></td>
<td><strong>IT-7.6</strong></td>
<td><strong>Urgent Dental Care Need:</strong> Percentage of children with urgent dental care needs.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 4 [I-14]:** Increase number of special population members that access dental services.

**Metric 1 [I-14.1]:** Increasing the number of children accessing dental services.
Baseline: Establish baseline
Goal: 2,400 visits
Data Source: EHR

Milestone 4 Estimated Incentive Payment: $1,389,762

**Milestone 5 [P-10]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

**Metric 1 [P-10.1]:**
Goal: Participate in learning collaborative
Data Source: Documentation of semi-annual meetings or seminars

Milestone 5 Estimated Incentive Payment: $1,389,762
<table>
<thead>
<tr>
<th>133355104.1.17</th>
<th>1.8.6</th>
<th>N/A</th>
<th><strong>THE EXPANSION OF EXISTING DENTAL CLINICS, THE ESTABLISHMENT OF ADDITIONAL DENTAL CLINICS, OR THE EXPANSION OF DENTAL CLINIC HOURS: EXPANSION OF PEDIATRIC DENTAL SERVICES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Harris Health System</strong></td>
<td>133355104</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td>133355104.3.31</td>
<td>IT-7.1</td>
<td>Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar within the measurement period</td>
</tr>
<tr>
<td></td>
<td>133355104.3.23</td>
<td>IT-7.4</td>
<td>Topical Fluoride application</td>
</tr>
<tr>
<td></td>
<td>133355104.3.32</td>
<td>IT-7.6</td>
<td>Urgent Dental Care Need: Percentage of children with urgent dental care needs</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $4,089,774</td>
<td>Year 3 Estimated Milestone Bundle Amount: $5,559,049</td>
<td>Year 4 Estimated Milestone Bundle Amount: $5,696,941</td>
<td>Year 5 Estimated Milestone Bundle Amount: $4,696,712</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add milestone bundle amounts over Years 2-5): $20,042,476</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Matagorda Regional Medical Center
Pass 1
Project Option 1.9.2 - Improve access to specialty care: Establish a Chronic Disease Clinic to Expand Access to Specialty Care

Unique RHP Project Identification Number: 130959304.1.1
Performing Provider Name/TPI: Matagorda Regional Medical Center/ 130959304

Project Summary:
Provider:
Matagorda Regional Medical Center is a wholly owned part of Matagorda County Hospital District. The District also operates a primary care clinic for patients qualified for the District’s Medical Assistance Program. The Hospital is a 58 bed acute care facility with a Level III trauma designation.

Volume Statistics - FY2012

<table>
<thead>
<tr>
<th>Statistics</th>
<th>FY2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions</td>
<td>2594</td>
</tr>
<tr>
<td>Births</td>
<td>381</td>
</tr>
<tr>
<td>Emergency visits</td>
<td>18600</td>
</tr>
<tr>
<td>Surgeries</td>
<td>1598</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>18260</td>
</tr>
</tbody>
</table>

Payor Mix

<table>
<thead>
<tr>
<th>Payor Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Pay</td>
</tr>
<tr>
<td>Medicaid and CHIP</td>
</tr>
<tr>
<td>Medicare</td>
</tr>
<tr>
<td>Commercial Insurance</td>
</tr>
<tr>
<td>Charity</td>
</tr>
</tbody>
</table>

Demographics

<table>
<thead>
<tr>
<th>Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>Caucasian</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

Intervention(s):
The CDSC will focus on providing access to specialty services and physicians that support care for a number of key chronic conditions identified by community need. Through the establishment of the CDSC, patient compliance with specialty referral visits will improve and the ability to manage chronic disease conditions on an ambulatory basis will improve. The CDSC will collaborate with the primary care community to share information, provide outreach to patients to improve compliance, collect and analyze data to improve systems, and ultimately improve the health of many. This project will also transform the care provided chronic illness patients in a remote part of the County by collaborating on the placement of the only primary care physician in Palacios.

Need for the project:
The chronic conditions as measured by the EHR of the local FQHC (MEHOP) indicates a rate of diabetes in the population of 26%, of hypertension of 46%, hyperlipidemia of 11% and COPD/Asthma at 3%. These rates are far above the rates for Texas and the nation. This clinic will bring resources to the community to improve treatment and compliance and ultimately reduce unnecessary hospital admissions.

Target Population:
All patients within the primary service area (Matagorda County) may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%), specifically those with chronic diseases.

Category 1 or 2 expected patient benefits:
Our 5 year goal is an increase of 100 patients from the baseline in active patients in the CDSC system and a reduction in the admission rate for acute care hospitalizations for ambulatory care sensitive conditions for individuals under 75 years of age by 10% from 2013 baseline for those patients of the chronic clinic.

Category 3 outcomes:
IT-2.11: Our goal is to reduce the admission rate for acute care hospitalizations for ambulatory care sensitive conditions for individuals under 75 years of age by 10% from DY2 base for those patients of the chronic clinic.
Project Option 1.9.2 - Improve access to specialty care: Establish a Chronic Disease Clinic to Expand Access to Specialty Care

Unique RHP Project Identification Number: 130959304.1.1

Performing Provider Name/TPI: Matagorda Regional Medical Center/ 130959304

Project Description:
Matagorda Regional Medical Center proposed to expand specialty care for targeted populations with chronic diseases.

Collectively motivated by a Robert Wood Johnson Foundation Report ranking Matagorda County 185 out of 221 Texas counties in key health domains, representatives of the County, hospitals, school districts, physicians, the FQHC, churches, mental health system, social agencies and more – came together as a task force to begin the dialogue on improving the health profile of the community.

A joint planning team was formed with representatives of Matagorda County Hospital District/Matagorda Regional Medical Center, Matagorda Episcopal Health Outreach Program (MEHOP – FQHC), and Palacios Community Medical Center to explore potential models for collaboration. The transformation goals described in the Waiver helped the group crystallize their plans and a new partnership was formed to move the joint planning effort forward. This new organization, Coastal Health Connection, is being incorporated to further the concept of shared infrastructure and shared planning to improve the health of the community. The DSRIP project to establish a Chronic Disease Specialty Clinic (CDSC) is an outgrowth of this shared vision of a healthier community. The chronic conditions as measured by the EHR of the local FQHC (MEHOP) indicates a rate of diabetes in the population of 26%, of hypertension of 46%, hyperlipidemia of 11% and COPD/Asthma at 3%. These rates are far above the rates for Texas and the nation. For example, diabetes in Texas is reported to be 9.7% and 9.3% in the nation. A review of hospital admission data from a 12 month period found a majority of patients had at least one of the targeted chronic disease conditions and that 10% of patients had a targeted chronic disease as a primary admitting diagnosis. Currently, primary care practitioners must often refer patients for specialty care to locations ranging from 45 - 90 minutes away. Most of the specific disease categories driving the poor overall health status of Matagorda County can be positively impacted by transforming care for the targeted population from one of fragmented resources to an organized system of care with the goal of reducing the rate of hospital admission. Through the use of collaborative funding from Palacios Community Medical Center, chronic disease management and ongoing access to primary care for the population of the predominantly rural Matagorda County will be provided.

The CDSC will focus on providing access to specialty services and physicians that support care for a number of key chronic conditions identified by community need. Through the establishment of the CDSC, patient compliance with specialty referral visits will improve and the ability to manage chronic disease conditions on an ambulatory basis will improve. The CDSC will collaborate with the primary care community to share information, provide outreach to patients to improve compliance, collect and analyze data to improve systems, and ultimately improve the health of many.
The CDSC will create and manage a data base of chronic disease patients to improve navigation through the system of care and to improve compliance and monitoring. This system will utilize the RHIE which is projected to be in place in Year 3 will connect primary care physicians to the chronic clinic. In addition to clinical staffing, care teams will be utilized to serve as a liaison between referring physicians, specialty physicians, the patients, and other components of the care continuum. These teams will be led by a case manager and utilize community health workers (CHW). Once enrolled, patients will receive follow-up phone calls, appointment reminders, case management services and support from the care coordinator. The Clinic will be located on the Hospital Campus to further the convenience for access to supporting diagnostics and specialized services such as educational programs, wound care, outpatient procedures, etc. A primary care physician will be placed in Palacios 2 days per week to manage the ongoing care for the population in the western part of the County. By placing a physician in the community to enhance services currently provided by a qualified extender and to collaborate with the CDSC, care in this rural section of the County will be transformed. Transportation beyond the transportation already provided by local FQHC will be evaluated and added as needed.

The target zip codes include all of those in Matagorda County and it is expected this clinic will receive patients from surrounding counties since the patient panels at MEHOP include patients from Matagorda, Wharton, Jackson, and Brazoria counties.

Target Zip Codes:
77414, 77404, 77456, 77465, 77457, 77419, 77458, 77415, 77428, 77440, 77480, 77483

**Project Goals and Relationship to Regional Goals:**
The objectives of this project are to (1) make access to specialty care more convenient and affordable by bringing services to the community and (2) provide care coordination to the chronic disease population in order to improve compliance and early disease intervention.

**Project Goals:**
- Increase the number of available specialty appointments for target chronic disease management. Baseline will be established in DY3 and anticipate providing 2000 patient appointments in DY4 and 3000 additional appointments in DY5. DY4 impact is projected to be 1000 patients and 1500 patients in DY5.
- Improve care coordination with primary care practitioners and other sectors of the care continuum.
- Decrease avoidable hospital admissions.
- Decrease number of disease related crisis visits to the emergency department.

This project meets the following Region 3 goals:
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.

**Challenges:**
The specialty physicians needed to collaborate with primary care practitioners in the care of patients with the target chronic diseases are generally not available in the region. Because several of the specialty physicians are not needed on a full-time basis, recruitment will be difficult and costly. Because of the socio-economic status of much of the patient population, physicians have been unable and/or unwilling to come to the area on a part-time basis or open their practice to the lower income population.

Due to the lack of resources available in the area, patients have been accustomed to being referred to a specialist located out of the area based on individual primary care preferences, self-referring, or choosing not to seek additional care. These patterns are long established and often multi-generational. Creating a new resource in the community will require changing the patterns of both the existing medical community and their patients. Collaborating with Palacios for a primary care physician will further the transformation of the care continuum through system support and patient management within the CDSC.

Finally, although the Chronic Disease Specialty Clinic will be located in the County’s population center, approximately 50% of the residents live in smaller outlying communities – some of which require as much as 30 minutes travel time. Transportation to the clinic will challenge some of the most vulnerable population to receive the specialty intervention.

Because the Chronic Disease Specialty Clinic will be fully staffed and supported on a local level with a clinic location conveniently located on the hospital campus, there is early positive indications of interest from large multi-specialty physician groups (Baylor, Texas Children’s) to become a contracted provider of those needed physician services. The infrastructure to be included in that clinic will provide the platform for the creation of care coordination teams and information systems to facilitate compliance and collaboration with the primary care physicians. The model will build on current successes with diabetes education in the community and include training for educators on other chronic disease categories. Because this clinic will be a reflection of the mission of Matagorda Regional Medical Center and the partners of Coastal Health Connection, specialty services will be available to the entire community regardless of ability to pay. Coastal Health Connection will play a role in coordinating existing transportation services and develop plans for expansion.

5-Year Expected Outcome for Provider and Patients:
Matagorda Regional Medical Center expects to see a decrease in the admission rate for the specified chronic diseases. By creating a system of care focused on a coordinated, collaborative approach and early intervention, patients will not be as likely to get “lost” and end up in health crises. The expected outcome is to reduce the admission rate for the population of patients managed through the Chronic Disease Specialty Clinic and the care coordination resources associated with the Clinic. Our goal is an increase of 100 patients from the baseline in active patients in the CDSC system and a reduction in the admission rate for acute care hospitalizations for ambulatory care sensitive conditions for individuals under 75 years of age by 10% from 2013 baseline for those patients of the chronic clinic.

Starting Point/Baseline:
A chronic disease specialty clinic does not exist for the Matagorda County region and therefore we have no patients in a system of care for chronic diseases.

Rationale:
The target chronic conditions as measured by the EHR of the local FQHC (MEHOP) indicates a rate of diabetes in the population of 26%, hypertension of 46%, hyperlipidemia of 11% and COPD/Asthma at 3%. These rates are way above the rates for Texas and the nation. For example, Diabetes in Texas is reported to be 9.7% and 9.3% in the nation. Matagorda and Wharton counties are medically underserved, dental health and mental health shortage areas. Matagorda County lists 26% of citizens living in poverty. The percentage of children age 0 to 17 years living under the poverty level is higher at 29.0% for Matagorda County. The largest school districts report nearly 75% of the children economically disadvantaged. In Bay City (county seat) alone this is a 25% increase in 10 years. Matagorda County ranked 185 out of 221 (County Health Rankings, 2011) and 110 out of 221 for Wharton County for health factors. The shortage of health care professionals coupled with high poverty defines a population in dire need of health care. Many patients don’t seek care until they can no longer work, or their illness keeps them virtually immobile. At this time they often seek care in the emergency room or at MEHOP. For many, the emergency room is seen as free care. MRH has worked closely with MEHOP to establish a primary care home for these patients. Once the chronic condition is identified, the condition is critically out of control. There is only one cardiologist in the area and no other specialist for the targeted chronic conditions.

Due to the economic condition of the patients, referral to specialists outside the area is virtually impossible. Specialists won’t accept the patient and/or the patient has no transportation. There is not currently a centralized location for determining best practice management of patients with the targeted disease categories. By creating a clinic with the respective specialists, data/information systems, and care coordination, patients and their primary care providers will have ready access to expertise that will reduce issues with non-compliance, reduce out of control health crises, and therefore reduce hospital admission rates and unnecessary visits to the emergency department.

**Project Components:**
The required core project components include the following:

a) Increase service availability with extended hours
b) Increase number of specialty clinic locations
c) Implement transparent, standardized referrals across the system
d) Conduct quality improvement for project using methods such as rapid cycle improvement

We will meet these project components with the establishment of the chronic disease specialty clinic as follows:

1. Identification of the type of specialists and the time commitment required to impact the chronic conditions/health disparities
   - Estimated cost for gap analysis: $50,000 - $75,000
2. Recruitment of the specialists, clinical support team and care team
   - Recruitment: $25,000/physician = $150,000
   - Staffing: $600,000/year (including physicians)
3. Equipping the facility to meet the needs of the specialists
   - New clinic: $290,000
4. Develop a collaborative model with the primary care community to utilize chronic clinic
   - Informational material, education, etc: $25,000/year
5. Establish of baseline metrics and then continual measurement for improvement
while utilizing process techniques such as PDSA cycles for improvement
- IT (patient tracking, scheduling, referral systems): $50,000 (one time) + $10,000/year

6. Technology – Utilizing RHIE, connect primary care physicians to the chronic clinic.
- $2500/physician = $25,000/year

7. Communication of success in the county, area and region.
- Educational material, etc.: $10,000

**Milestones & Metrics:**
The following milestones and metrics have been chosen for the Chronic Care Clinic project based on the core components and the needs of the target population:
- Process Milestones and Metrics: P-1 (P-1.1); P-3 (P-3.1); P-4 (P-4.1); P-8 (P-8.1); P-9; P-11 (P-11.1)
- Improvement Milestones and Metrics: I-22 (I-22.1); I-23 (I-23.1); I-29 (I-29.1)

**Unique community need identification number the project addresses:**
The project addresses the following unique community needs as identified in the community needs assessment:
- CN.1 Access to Specialty Care for Chronic Conditions within Matagorda County
- CN.2 Population Diabetes rate of 26%; Hypertension rate of 45%; Hyperlipidemia of 11%; as well as 3% COPD
- CN.3 Percent Uninsured (29.2%) and Percent Poverty (22%) in Matagorda County
- CN.4 HPSA score of 16

**How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:**
For the key chronic conditions of hypertension, hyperlipidemia, diabetes, COPD and asthma there is one cardiologist and no other specialists in the county or nearby region. A clinic established to focus on the management of these critical chronic diseases in the greater Matagorda County region will reduce ambulatory care sensitive admissions and dramatically improve primary care physician’s ability to control these long term diseases.

**Related Category 3 Outcome Measure(s):**
OD-2 Potentially Preventable Admissions:
IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate
- Rate of acute care hospitalizations for grand ma status and other epileptic convulsions, Chronic obstructive pulmonary diseases (COPD), asthma, heart failure, pulmonary edema, hypertension, angina, diabetes

**Reasons/rationale for selecting the outcome measure(s):**
The high percentage of the population as uninsured and high poverty creates a challenging approach for primary care physicians to control these chronic diseases. Frequently, a patient lives with a chronic disease for an extended period before seeking primary care. In many cases, specialty care is required to assist the primary physician in finding appropriate approaches to controlling the disease. With the exception of one cardiologist, there are no specialty care physicians within driving distance (30 miles) for the patient. Preventable
hospitalizations for Matagorda County for Hypertension, COPD, Asthma, and short and long term Diabetes increased 44% from 2008 to 2010. This accounts for increased expenses over this period of over $1,000,000. With the rate of diabetes as measured by MEHOP at 3 times the national average, hospital discharges would be predicted to be at a higher than average rate as well. The establishment of a specialty chronic clinic will enable the primary care physicians to refer these patients for care and subsequently controlling these chronic diseases.

**Relationship to Other Projects:**
There are no other projects planned.

**Relationship to Other Performing Providers’ Projects in the RHP:**
Healthcare costs are significantly increased within a patient base with such aggressive chronic conditions that have gone untreated. The initiatives focused to chronic disease management focus to conditions such as asthma, hypertension, and diabetes and are similar in the approach of managing & proactively treating chronic conditions in order to reduce 30-day readmission rates, inappropriate emergency department utilization, and healthcare costs. The Region 3 Initiative grid allows a cross reference of initiatives associated with chronic disease management. (addendum)

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

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

**Project Valuation:**
Matagorda County has an estimated population of 2850 people with diabetes; 4500 people with hypertension and 1050 with hyperlipidemia who are at poverty or below. Of the general population over 1000 have COPD or asthma. The value of the CDSC will be to control these chronic diseases and thereby improve the quality of life for these individuals. The impact of reduced preventable hospitalizations will be a savings compared to the base year of 2010 of $500,000 in year 4 and additional savings of $100,000 per year for the next 3 years. (This is a reduction of an additional 5 preventable hospitalizations per year. Year 5 savings of $600,000. Year 6 savings of $700,000, etc.)

Although only one project has been selected, the ability to create a comprehensive infrastructure for chronic disease management is critical to success in the desired outcomes. That infrastructure must include at least the following:

- Identification of the type of specialists and the time commitment required to impact the
chronic conditions/health disparities
✓ Recruitment of the specialists, clinical support team and care team
✓ Equipping the facility to meet the needs of the specialist
✓ Develop a collaborative model with the primary care community to utilize chronic clinic
✓ Establish of baseline metrics and then continual measurement for improvement while utilizing process techniques such as PDSA cycles for improvement
✓ Technology – Utilizing RHIE, connect primary care physicians to the chronic clinic.
✓ Communication of success in the county, area and region.

1&2 DSHS, 2009 County Facts Profile, http://www.dshs.state.tx.us/chs
3 Date reported to MEHOP by BCISD June/2012
4 DSHS, 2009 County Facts Profile, http://www.dshs.state.tx.us/ph
### Chronic Care Clinic

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>CHRONIC CARE CLINIC</th>
<th>130959304</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matagorda Regional Medical Center</td>
<td>OD-2</td>
<td>Matagorda Regional Medical Center</td>
<td>130959304</td>
</tr>
</tbody>
</table>

#### Outcome Measure(s):
- OD-2
- IT-2.11

#### Year 2
(10/1/2012 – 9/30/2013)

**Milestone 1** [P-1]: Conduct specialty care gap assessment based on community need

**Metric 1** [P-1.1]: Document gap assessment of high demand specialty areas to build up supply of specialists to meet demand and improve specialty access

- Baseline: No gap assessment has been conducted
- Goal: Completion of gap assessment
- Data Source: Community Needs Assessment; Gap analysis; EHR

**Milestone 1 Estimated Incentive Payment (maximum amount): $523,067**

**Milestone 2** [P-11]: Launch/expand a specialty care clinic.

**Metric 1** [P-11.1]: Establish chronic care clinic

- Baseline: There is currently no specialty chronic care clinic
- Goal: Recruit specialty physicians (part and full time) as gap analysis indicates. Provide facilities for specialty physicians in Doman Freeman Phillips Medical Office

**Milestone 3** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties.

**Metric 1** [I-22.1]: Specialists added to meet demand

- Baseline: One cardiologist practices in Matagorda County; no pulmonologist, oncologist, endocrinologist, gastroenterologist or rheumatologist practices in Matagorda County.
- Goal: Specialists are recruited as identified by gap analysis.
- Hire at least 3 specialists by the end of the project.
- Data Source: HR documents or other documentation demonstrating employed/contracted specialists

**Milestone 3 Estimated Incentive Payment: $570,637**

**Milestone 4** [P-8]: Develop the technical capabilities to facilitate electronic referral

**Metric 1** [P-8.1]: Utilizing HIET, provide technical capability to

#### Year 3
(10/1/2013 – 9/30/2014)

**Milestone 5** [P-4]: Expand the ambulatory care medical specialties referral management department and related functions

**Metric 1** [P-4.1]: Referral Management System Utilization

- Baseline: Number of unique referrals placed and tracked within the system during year 3
- Goal: 250 unique referrals placed
- Data Source: EHR

**Baseline: Year 3 specialist added – 1 pulmonologist.**

**Goal: Additional specialists added as identified in the gap analysis – projected to be an endocrinologist, and cardiologist.**

**Milestone 5: Estimated Incentive Payment: $190,765**

**Milestone 6** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties.

**Metric 1** [I-22.1]: Specialists added to meet demand

- Baseline: Year 3 specialist added – 1 pulmonologist.
- Goal: Additional specialists added as identified in the gap analysis – projected to be an endocrinologist, and cardiologist.
- Data Source: HR documents or other documentation

**Milestone 11 Estimated Incentive Payment: $472,766**

#### Year 4
(10/1/2014 – 9/30/2015)

**Milestone 7** [P-4]: Expand the ambulatory care medical specialties referral management department and related functions

**Metric 1** [P-4.1]: Referral Management System Utilization

- Baseline: Number of unique referrals placed and tracked within the system during DY4
- Goal: Increase number of visits by 50% from DY4
- Data Source: UDS Report – MEHOP; EHR

**Milestone 7 Estimated Incentive Payment: $25,000**

#### Year 5
(10/1/2015 – 9/30/2016)

**Milestone 11** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patient’s services.

**Metric 1** [I-23.1]: Documentation of increase number of visits.

- Demonstrate improvement over prior reporting period
- Baseline: Year 4 specialty patient encounters and visits
- Goal: Increase number of visits by 50% from DY4
- Data Source: UDS Report – MEHOP; EHR

**Milestone 11 Estimated Incentive Payment: $472,766**

#### Year 6
(10/1/2016 – 9/30/2017)

**Milestone 14** [P-4]: Expand the ambulatory care medical specialties referral management department and related functions

**Metric 1** [P-4.1]: Referral Management System Utilization

- Baseline: Number of unique referrals placed and tracked within the system during DY4
- Goal: Increase number of unique referrals placed and tracked by 50%
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building available spring 2013. Market availability of chronic specialty care to county/region. Data source: documentation of new chronic care clinic</td>
<td>primary care providers who utilize the Chronic Clinic to directly refer patients into schedule. Baseline: No electronic referral system in place. Goal: Install capability at all primary care doctors by end of year 3. Data Source: HER</td>
<td>demonstrating employed/contracted specialists Milestone 6 Estimated Incentive Payment: $190,766 <strong>Milestone 7</strong> [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patient’s services. Metric 1 [I-23.1]: Documentation of increase number of visits. Demonstrate improvement over prior reporting period Baseline: Total number of Year 3 visits Goal: Number of visits increase from year 3 by 2000. Data Source: EHR Milestone 7 Estimated Incentive Payment: $190,765 <strong>Milestone 8</strong> [P-3]: Collect baseline data for wait times, backlog, and/or return appointments in specialties Metric 1 [P-3.1]: Establish baseline for performance indicators Baseline: Not yet developed Goal: Establish baseline Data Source: EHR</td>
<td>over DY4 Data Source: EHR Milestone 14 Estimated Incentive Payment: $472,766</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>1.9.2</td>
<td>1.9.2(A-D)</td>
<td>CHRONIC CARE CLINIC</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------</td>
<td>----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Matagorda Regional Medical Center</td>
<td></td>
<td></td>
<td>130959304</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OD-2</th>
<th>IT-2.11</th>
<th>Ambulatory Care Sensitive Conditions Admissions Rate</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>

**Milestone 8 Estimated Incentive Payment:** $190,766

**Milestone 9 [P-9]:** Implement referral technology and processes that enable improved and more streamlined provider communications

**Metric 1 [P-9.1] Documentation of referrals technology**
Baseline: Providers using technology DY3
Goal: Increase number of providers using referral technology by 5
Data Source: EHR, Referral system

**Milestone 9 Estimated Incentive Payment:** $190,766

**Milestone 10 [I-29]:** Increase the number of referrals of targeted patients to the specialty care clinic

**Metric 1 [I-29.1] Targeted referral rate**
Baseline: number of referrals of targeted patients in Year 3
Goal: Increase number of patients referred by 50% from DY3.
Data Source: EHR

**Milestone 10 Estimated Incentive Payment:**
<table>
<thead>
<tr>
<th>130959304, 1.1</th>
<th>1.9.2</th>
<th>1.9.2(A-D)</th>
<th>CHRONIC CARE CLINIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matagorda Regional Medical Center</td>
<td></td>
<td></td>
<td>130959304</td>
</tr>
</tbody>
</table>

**Related Category 3 Outcome Measure(s):**
- OD-2
- IT-2.11

**Ambulatory Care Sensitive Conditions Admissions Rate**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

- **Payment:** $190,765
- **Year 2 Estimated Milestone Bundle Amount:** $1,046,133
- **Year 3 Estimated Milestone Bundle Amount:** $1,141,275
- **Year 4 Estimated Milestone Bundle Amount:** $1,144,593
- **Year 5 Estimated Milestone Bundle Amount:** $945,532

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $4,277,533
Matagorda Regional Medical Center
Pass 3
Project Summary:

Provider: Matagorda Regional Medical Center is a wholly owned part of Matagorda County Hospital District. The District also operates a primary care clinic for patients qualified for the District’s Medical Assistance Program (Indigent). The Hospital is a 58 bed acute care facility with a Level III trauma designation.

Volume Statistics - FY2012

<table>
<thead>
<tr>
<th>Hospital admissions</th>
<th>Births</th>
<th>Emergency visits</th>
<th>Surgeries</th>
<th>Outpatient visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>2594</td>
<td>381</td>
<td>18600</td>
<td>1598</td>
<td>18260</td>
</tr>
</tbody>
</table>

Patient Payor Mix

- Self-Pay: 11.5%
- Medicaid and CHIP: 12.8%
- Medicare: 50.1%
- Commercial Insurance: 22.5%
- Charity: 3.1%

Patient Demographics

- Hispanic: 31.1%
- African American: 17.2%
- Caucasian: 50.1%
- Other: 1.6%

Intervention(s):

To provide an alternative to care at the right time and right setting primary and urgent care services will be expanded to evenings and weekends. A nurse advice line manned with RN professionals trained in pediatric as well as adult triage will promote the use of the expanded primary and urgent care services.

Need for the project:

While there has been positive progress in expanding access to community based care, current data reflects that between 40 and 50% of Matagorda Regional Medical Center Emergency Department visits are for diagnosis that could safely be treated in a clinic setting. A nurse advise line does not exist for the Matagorda County region nor does expanded night and weekend hours for primary and urgent care for Medicaid, indigent and the underserved and uninsured.

Target Population:

All patients within the primary service area (Matagorda County) may benefit from this project (Medicaid and CHIP: 23.4% / Self-Pay: 62.6%), specifically those with repetitive unnecessary ED visits.

Category 1 or 2 expected patient benefits:

The projection for patient impact for increased primary care and urgent care is DY 3 1000 visits and 700 patients, DY 4 2000 visits and 1250 patients and DY 5 2500 visits and 1600 patients.

Category 3 outcomes:

IT-9.2: Our goal is a 15% reduction in unnecessary Emergency Department visits from DY2 base.
Project Option 1.1.2- Expand Existing Primary Care

**Unique RHP Project Identification Number:** 130959304.1.3/Pass 3

**Performing Provider Name/TPI:** Matagorda Regional Medical Center/ 130959304

**Project Description:**
A joint planning team with representatives of Matagorda County Hospital District/Matagorda Regional Medical Center, Matagorda Episcopal Health Outreach Program (MEHOP – FQHC), and Palacios Community Medical Center has explored potential models to transform access, cost and delivery of health care. The transformation goals described in the Waiver helped the group crystallize their plans and a new partnership was formed to move the joint planning effort forward. This new collaborative organization, Coastal Health Connection, is currently being incorporated with these three organizations as the founders to further the concept of shared infrastructure and shared planning to improve the health of the community.

The DSRIP project to expand primary care services to include expanded space, expanded hours and staffing to provide primary and urgent care as well as 24/7 nurse advice. This project is consistent with the goals of a shared vision of a healthier community. While there has been positive progress in expanding access to community based primary care, recent data reflects that between 40 and 50% of Matagorda Regional Medical Center Emergency Department visits are for diagnosis that could safely be treated in a clinic setting. The data further indicates low utilization of inpatient services by pediatric patients. It is proposed that urgent pediatric needs and/or inpatient services are unmet in the county. For underserved/underinsured patients access to care after normal hours is not available. There is no nurse care advice line to triage patients seeking primary care services. Expanding primary care at the site of the FQHC will provide an introduction of patients to a primary care home setting and thereby engage these patients with a holistic approach to healthcare. The continued inappropriate use of the hospital emergency department as a source of non-emergent care underscores the need for a call center to timely triage patients and for a source for expanded hours urgent care. Transportation beyond the transportation already provided by local FQHC will be evaluated and added as needed.

The target zip codes include all of those in Matagorda County and it is expected this clinic will receive patients from surrounding counties since the patient panels at MEHOP include patients from Matagorda, Wharton, Jackson, and Brazoria counties. Target Zip Codes: 77414,77404,77456,77465,77457,77419,77458,77415,77428,77440,77480,77483

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

**Project Goals:**
- Establish nurse advice line so that patients who need it can access it telephonically
- Provide extended hours of primary for Medicaid, indigent and anyone needing primary and urgent care
- Evaluate required additional clinic space and add as required.
- Decrease inappropriate visits for hospital emergency department using nurse advise line

This project meets the following Region 3 goals:
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and
health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.

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

**Challenges or Issues Faced:**
Data collected by MCHD as well as MEHOP indicates a section of the population continually utilizes the emergency department (ED) as a source of primary care. This illustrates the need for transformation to the approach to healthcare by the community. The behaviors of individuals and families to care illustrate entrenched beliefs that ED care is a minimal cost, primary care choice. Communication and demonstration of access to high quality care is paramount.
Communication and demonstration of the availability of advice and care to a county where 50% of the residents live outside the county seat in remote low density areas will be critical to the success of the transformation. There currently is not any source of nurse advice for patients and parents to seek direction on appropriate venue for care. Finally, there are limited alternatives to the hospital emergency room for after hours and weekend care and no alternative for the uninsured and underinsured.

**How the Project Addresses Challenges/Issues:**
The availability of a nurse advice line will enable health concerns to be heard and addressed in an optimum venue of care. Primary and urgent care will be available in a non ED setting for expanded hours and weekends to reduce the number of unnecessary ED visits. Utilization of electronic health records and health information technology will facilitate continuity of care. Because this clinic will be a reflection of the mission of Matagorda Regional Medical Center and the partners of Coastal Health Connection services will be available to the entire community regardless of ability to pay. Coastal Health Connection will play a role in coordinating existing transportation services and develop plans for expansion.

**5-Year Expected Outcome for Provider and Patients:**
Matagorda Regional Medical Center expects to see a decrease in the number of unnecessary visits to the ED by patients utilizing the call center and expanded urgent and walk-in care. Through continuity of approach to health care within Coastal Health Connection including formal communication networks between nurse advise line and community based navigators it is anticipated that patients will receive the right care in the right setting. Consistent intervention with this collaborative approach will promote primary care in a patient centered home model where the patient receives care for both chronic and acute illnesses and health disparities are reduced. The projection for patient impact is DY3 1000 visits and 700 patients, DY4 2000 visits and 1250 patients and DY5 2500 visits and 1600 patients. The expected outcome is to reduce the unnecessary ED visits creating a system of care focused on a coordinated, collaborative approach and early intervention, patients will be not be as likely to get “lost” and end up in a health crisis. Our goal is to reduce unnecessary ED visits by 15% from a baseline determined in DY2.

**Starting Point/Baseline:**
An nurse advice line does not exist for the Matagorda County region nor does expanded night and weekend hours for primary and urgent care in a primary care setting for the indigent, Medicaid and the underserved and uninsured.

**Rationale:**

**Reasons for selecting the project option:**
The county is served by two acute care hospitals, Matagorda Regional Medical Center and Palacios Community Medical Center. In 2010, the facilities reported 19,368 emergency visits. The hospitals provided more than $16 million in uncompensated care, which accounted for 14.9% of total patient revenue, the second highest percentage in the region. Between 40 and 50% of the visits to the MRMC Emergency Department in 2012 could be considered non-emergent and potentially could be cared for in a less costly venue. MCHD provides indigent primary care during regular business hours and inpatient care while MEHOP provides primary care with limited expanded hours for all and specifically underserved, uninsured, Medicaid and Medicare patients. Matagorda County includes the towns of Bay City and Palacios, as well as 15 smaller communities spread throughout the county of more than 1,000 square miles. More than 36,000 people live within the county which has a median household income of $39,874. Nearly 20% of the population lives below the poverty level, the uninsured rate is among the highest in Texas at 29.2% and the county has the second highest rate of children living in poverty at 28.4%. The population has demonstrated that care is often either not sought or the ED is used for primary care. A change is required to enable patients to receive advice 24/7 and to receive primary and urgent care in a primary care setting. No urgent care medical advice is available by phone for the population.

**Project Components:**
The key project components for expanding existing primary care, adding enhanced urgent care; and 24/7 medical advice include:

1. Expand primary and urgent care services at MEHOP from 6pm to 11pm Monday through Friday and Saturday and Sunday from 8am to 6pm
   - Recruitment of providers and support staff: $25,000
   - Staffing: $530,000-providers, nurse, insurance verification
   - Supplies: $25,000 on going
   - Security: $25,000
   - IT (Computers, licenses) - $50,000
   - Purchased Services - $200,000

2. Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use of non-emergent conditions and increase patient access to health care
   - Staffing: $200,000
   - Telephone System: $15,000
   - IT (scheduling, referral systems, patient tracking): $20,000 one time and $10,000 per year

3. Establish a process that in a timely manner triages patients seeking primary care services in an ED to an alternate primary care site.
   - Informational Material; $10,000

4. Survey patients who utilize nurse advise line and expanded urgent care to ensure
patient satisfaction with services received
   ▪ Survey: $10,000

5. Establish linkages between primary care, urgent care and ED in order to increase communication and improve care transitions
   ▪ Staff: $30,000

6. Conduct quality improvement for project using methods such as rapid cycle improvement
   ▪ Staff: $20,000

7. Communication of success in the county, area and region.
   ▪ Educational material, etc.: $10,000

Milestones & Metrics:
The following milestones and metrics have been chosen for enhanced urgent medical advice and expanded urgent care services project based on the core components and the needs of the target population. Process Milestones and Metrics: P-1 (P-1.1); P-4 (P-4.1); P-5 (P-5.1), P-7 (P-7.1); I-11(I-11.1); I-12 (I-12.1); I-13 (I-13.1); I-14 (I-14.1); and I-14 (I-14.5)

Unique community need identification number the project addresses:
The project addresses the following unique community needs as identified in the community needs assessment:
CN.1  Inadequate access to primary care
CN.8  High rates of inappropriate emergency department utilization
CN.23 Lack of patient navigation, patient and family education and information programs.

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
The main focus of the hospital district has been acute focused with hospital and emergency department services. This new initiative solidifies a partnership with the hospital district and the FQHC. This initiative combined with patient navigator system will enable patients to receive the right care in the right setting and will promote the patient centered medical home initiative. The project will also enhance another project of creating a system of care for chronic diseases by identifying undetected chronic disease and enabling patients to receive urgent care within the collaborative system.

Related Category 3 Outcome Measure(s):
OD-9 Right Care Right Setting:
IT-9.2 ED Appropriate utilization
   ▪ Reduce all ED visits (including ACSC)\(^1\)
   ▪ Reduce pediatric Emergency Department visits (CHIPRA Core Measure)\(^2\)
   ▪ Reduce Emergency Department visits for target conditions
      ○ Congestive Heart Failure
      ○ Diabetes
      ○ End Stage Renal Disease

\(^1\)http://archive.ahrq.gov/data/safetynet/billappb.htm
Reasons/rationale for selecting the outcome measure(s):
A high percentage of the population being uninsured, low income, and under-educated, causes connecting to the right setting for care can be challenging. The barriers created by these factors include economic and communication. Generations of families have come to rely on the emergency department of hospitals as their sole source of health care or avoided care until life was threatened.

While there are many factors involved in calculating actual cost savings available if a patient receives care in the most cost effective setting, the charge associated with the lowest acuity visit for a local hospital ED visit is over double that of the same coded visit in a local community clinic.³ With over 8000 emergency department visits per year in Matagorda County potentially being eligible for care in a different venue, the impact could be significant.

Relationship to Other Projects:
MCHD is also developing a Chronic Disease Specialty Clinic. Enhanced urgent care medical advice and expanded urgent care will partner with the Patient Care Navigation System that is being developed. All of these projects will overlap with an integrated referral system and have positive impact on appropriate use of the ED and reduce health disparities.

Relationship to Other Performing Providers’ Projects in the RHP:
Matagorda Regional Medical Center is the only performing provider in this project.

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

Project Valuation:
Matagorda County Regional Medical Center has approximately 20,000 visits to the Emergency Department annually. Records reflect a potential of 40 – 50%⁴ of the visits could have been treated in another venue. If the Enhanced and expanded urgent care is successful at reducing unnecessary ED visits by a conservative 15%, a savings of as much as $3,000,000⁵ could be realized by the end of the project period (as compared to a standard physician office visit).

¹ & ² DSHS, 2009 County Facts Profile, http://www.dshs.state.tx.us/chs

³ MCHD, MEHOP charge master
⁴ MCHD ED Records 2012
⁵ Cost of an average ED visit compared to an office visit. Consumer Health Ratings, 2011
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>EXPAND EXISTING PRIMARY CARE CAPACITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matagorda Regional Medical Center</td>
<td>130959304</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Milestone 1 [P-1]: Establish additional/expand existing/relocate primary care clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space</td>
<td>baseline: MEHOP is open 7am to 6pm Monday through Friday and 4 hours on Saturday once per month with 4 medical providers serving 3700 patients.</td>
</tr>
<tr>
<td>Goal: Evaluate need for expanded facility and hours and document detailed expansion plans by June 2013</td>
<td>Data Source: MEHOP EHR, expansion plans</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment (maximum amount):</td>
<td>$172,597</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Milestone 2 [P-5]: Train/Hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 2 [P-5.1]: Documentation of increased number of providers and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 3 [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours</td>
<td></td>
</tr>
<tr>
<td>Metric 4 [P-4.1]: Increased number of hours at primary care clinic over baseline</td>
<td></td>
</tr>
<tr>
<td>Baseline: MEHOP is open 7am to 6pm Monday through Friday and 4 hours on Saturday once per month with 4 medical providers serving 3700 patients.</td>
<td></td>
</tr>
<tr>
<td>Goal: Based on define needs expand clinic into the evenings five days a week and expand services to include Saturday and Sunday by 10/1/2013</td>
<td></td>
</tr>
<tr>
<td>Data source: EHR, Expansion Plan Milestone 2 Estimated Incentive Payment: $145,994</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Milestone 4 [P-13]: Enhanced capacity to provide urgent care services in the primary care setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 5 [P-13.1]: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 2 calendar days of request. Demonstrate improvement over baseline rate.</td>
<td></td>
</tr>
<tr>
<td>Baseline: Year 3 urgent care visits at MEHOP</td>
<td></td>
</tr>
<tr>
<td>Goal: 150% (750 visits)</td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR, Call center records, ED visits</td>
<td></td>
</tr>
<tr>
<td>Milestone 8 Estimated Incentive Payment $119,654</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
<th>Milestone 5 [I-13]: Enhanced capacity to provide urgent care services in the primary care setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 6 [I-13.1]: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 2 calendar days of request. Demonstrate improvement over baseline rate.</td>
<td></td>
</tr>
<tr>
<td>Baseline: Year 3 urgent care visits at MEHOP</td>
<td></td>
</tr>
<tr>
<td>Goal: 150% (750 visits)</td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR, Call center records, ED visits</td>
<td></td>
</tr>
<tr>
<td>Milestone 9 Estimated Incentive Payment $98,400</td>
<td></td>
</tr>
</tbody>
</table>

| Milestone 6 [I-11]: Patient Satisfaction with primary care services | 
| Metric 7 [I-11.1]: Patient Satisfaction Scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores | Baseline: Improve patient satisfaction | 
| Milestone 10 Estimated Incentive Payment $119,654 | 

| Milestone 7 [I-11]: Patient Satisfaction with primary care services | 
| Metric 8 [I-11.1]: Patient Satisfaction Scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores | Baseline: Improve patient satisfaction | 
| Milestone 11 Estimated Incentive Payment $98,400 | 

| Milestone 8 [I-13]: Enhanced capacity to provide urgent care services in the primary care setting |
| Metric 9 [I-13.1]: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 2 calendar days of request. Demonstrate improvement over baseline rate. | 
| Baseline: Year 3 urgent care visits at MEHOP | 
| Goal: 150% (750 visits) | 
| Data Source: EHR, Call center records, ED visits | 
| Milestone 12 Estimated Incentive Payment $119,654 | 

| Milestone 9 [I-11]: Patient Satisfaction with primary care services | 
| Metric 10 [I-11.1]: Patient Satisfaction Scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores | Baseline: Improve patient satisfaction | 
| Milestone 13 Estimated Incentive Payment $98,400 | 

| Milestone 10 [I-13]: Enhanced capacity to provide urgent care services in the primary care setting |
| Metric 11 [I-13.1]: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 2 calendar days of request. Demonstrate improvement over baseline rate. | 
| Baseline: Year 3 urgent care visits at MEHOP | 
| Goal: 150% (750 visits) | 
| Data Source: EHR, Call center records, ED visits | 
| Milestone 14 Estimated Incentive Payment $98,400 | 

<p>| Milestone 11 [I-11]: Patient Satisfaction with primary care services |
| Metric 12 [I-11.1]: Patient Satisfaction Scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores | Baseline: Improve patient satisfaction |
| Milestone 15 Estimated Incentive Payment $98,400 |</p>
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>OD-9</td>
<td>IT-9.2</td>
</tr>
<tr>
<td>ED appropriate utilization</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>staff and/or clinic sites</td>
<td>over baseline rate.</td>
<td>Goal: Improve patient satisfaction by 10% over baseline.</td>
<td>by 20% over baseline.</td>
</tr>
<tr>
<td>Baseline: MEHOP has 4 medical providers</td>
<td>Baseline: Establish the baseline for this measurement DY3 (500 visits)</td>
<td>Data Source: CAHPS scores</td>
<td>Data Source: CAHPS scores</td>
</tr>
<tr>
<td>Goal: Hire additional staff by 9/30/13</td>
<td>Goal: Promote the use of MEHOP after hour services and document visits in EHR/HEIT as primary or urgent visit.</td>
<td>Milestone 9 Estimated Incentive Payment $119,654</td>
<td>Milestone 14 Estimated Incentive Payment $98,401</td>
</tr>
<tr>
<td>Data Source; EHR, HIT,</td>
<td>Data Source: EHR, Call center records, ED visits</td>
<td><strong>Milestone 10(I-12)</strong> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services</td>
<td><strong>Milestone 15(I-12)</strong> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $172,597</td>
<td>Milestone 5 Estimated Incentive Payment $145,994</td>
<td>Metric 10 (I-12.1) Documentation of increased number of visits. Demonstrate improvement over prior reporting period.</td>
<td>Metric 15 (I-12.1) Documentation of increased number of visits. Demonstrate improvement over prior reporting period.</td>
</tr>
<tr>
<td><strong>Milestone 3 (P-7)</strong> Establish a nurse advice line and/or primary care patient appointment unit.</td>
<td><strong>Milestone 6 (I-11) Patient Satisfaction with primary care services</strong></td>
<td>Baseline: DY3</td>
<td>Baseline: DY3</td>
</tr>
<tr>
<td>Data Source: EHR, HIET, logs of patient calls</td>
<td>Metric 6 (I-11.1): Patient Satisfaction Scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores</td>
<td>Goal: Increase number of visits by 250% (1250 visits) in the expanded hours of operation.</td>
<td>Goal: Increase number of visits by 300% (1500 visits) in the expanded hours of operation.</td>
</tr>
<tr>
<td>Milestone 3 Estimated Incentive Payment $172,598</td>
<td>Baseline: DY 3 is baseline year</td>
<td>Data Source: EHR, ED visits</td>
<td>Data Source: EHR, ED visits</td>
</tr>
<tr>
<td>Goal: Implement CAHPS assessment tool and establish baseline of customer satisfaction</td>
<td>Goal: Implement CAHPS assessment tool and establish baseline of customer satisfaction</td>
<td>Milestone 10 Estimated Incentive Payment $119,655</td>
<td>Milestone 15 Estimated Incentive Payment $98,401</td>
</tr>
<tr>
<td>Data Source: CAHPS scores</td>
<td>Data Source: CAHPS scores</td>
<td><strong>Milestone 11 (I-14)</strong> Increase the number of patients served and questions addressed on the nurse advice line and patient scheduling unit. Demonstrate improvement over prior reporting period</td>
<td><strong>Milestone 16 (I-14)</strong> Increase the number of patients served and questions addressed on the nurse advice line and patient scheduling unit. Demonstrate improvement over prior reporting period</td>
</tr>
<tr>
<td>Milestone 6 Estimated Incentive Payment $145,995</td>
<td>Milestone 6 Estimated Incentive Payment $145,995</td>
<td>Baseline: DY3</td>
<td>Baseline: DY3</td>
</tr>
<tr>
<td><strong>Milestone 7 (P-7)</strong> Establish a nurse advice line and/or primary care patient appointment unit.</td>
<td>Goal: Improve patient satisfaction by 10% over baseline.</td>
<td>Goal: Increase number of visits by 250% (1250 visits) in the expanded hours of operation.</td>
<td>Goal: Increase number of visits by 300% (1500 visits) in the expanded hours of operation.</td>
</tr>
<tr>
<td>Milestone 7 Estimated Incentive Payment $172,598</td>
<td>Data Source: CAHPS scores</td>
<td>Data Source: EHR, ED visits</td>
<td>Data Source: EHR, ED visits</td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan
Region 3

315
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Expansion Existing Primary Care Capacity</th>
<th>Matagorda Regional Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>OD-9</td>
<td>1.1.2</td>
<td>EXPAND EXISTING PRIMARY CARE CAPACITY</td>
<td>Matagorda Regional Medical Center</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

| 
| Advice line and/or primary care patient appointment unit. Metric 7 [P-7.1]: Documentation of nurse advise line and/or primary care patient appointment unit. Baseline: Establish baseline DY3 Goal: Establish baseline for nurse advise line. Data Source: EHR, HIET, logs of patient calls Milestone 7 Estimated Incentive Payment $145,995 | 
| Goal: Increase number of patients served by 25% Data Source: EHR, Call Records, HIET Milestone 11 Estimated Incentive Payment $119,655 
Milestone 12 Increase the number of patients served and questions addressed on the nurse advise line and patient scheduling unit. Demonstrate improvement over prior reporting period. Metric 16 (I-14.5) Nurse advice line/patient scheduling line quality indicator: First call resolution rate Baseline Line: Establish base DY4 Goal: Establish a protocol to determine if calls are completed with single contact of nurse advice line Data Source: Call records, EHR Milestone 12 Estimated Incentive Payment $119,655 | 
| served by 50% Data Source: EHR, Call Records, HIET Milestone 16 Estimated Incentive Payment $98,401 
Milestone 17 Increase the number of patients served and questions addressed on the nurse advise line and patient scheduling unit. Demonstrate improvement over prior reporting period. Metric 17 (I-14.5) Nurse advice line/patient scheduling line quality indicator: First call resolution rate Baseline Line: DY4 calls Goal: Improve first call resolution by 25% Data Source: Call Records, EHR, call records Milestone 17 Estimated Incentive Payment $98,401 | 

| Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $517,791 | Year 3 Estimated Milestone Bundle Amount: $583,978 | Year 4 Estimated Milestone Bundle Amount: $598,273 | Year 5 Estimated Milestone Bundle Amount: $492,004 |

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $2,192,047
Memorial Hermann Hospital

Pass 1
Project Option: 1.1.1 Establish more primary care clinics: Physician Network Development
Performing Provider: Memorial Hermann Hospital/TPI 137805107
Unique Project ID: 137805107.1.1

- **Provider:** Memorial Hermann Hospital (Memorial) is an 860 bed hospital located in Houston, TX and is part of the Houston-Sugarland-Baytown MSA. The MSA population served by Memorial is approximately 6,000,000 people.

- **Intervention(s):** Memorial will expand the capacity of primary care through more clinics and available health care professionals to better accommodate the regional patient population and community so that patients have enhanced access to services. Memorial will aim to recruit 60+ new primary care providers and 18 new primary care locations are planned.

- **Need for the project:** The region has a growing shortage of primary care providers due to the aging population needing primary care services and the decline of new doctors interested in pursuing primary care. Expanding primary care clinics with extended hours will increase access and capacity and help create an organized structure of primary care providers, clinicians and staff.

- **Target population:** The target population is patients in the Houston Community including Downtown, Katy, the Inner Loop, Clear Lake, North and Northeast Houston. Memorial estimates the expanded primary care capacity will be able to serve an additional 100,000 to 150,000 people once the project is fully operational, 37.55% of which are anticipated to be Medicaid or uninsured.

- **Category 1 or 2 expected patient benefits:** Patients with limited primary care access often seek treatment for low acuity conditions at Emergency Departments which have a higher degree of unsatisfactory results and stress to the patient. The additional primary care capacity could decrease unnecessary ER visits by approximately 5% in DY2 and 15% over the DY2 baseline in DY5.

Over the course of the project, Memorial expects approximately 743,000 patient visits as a result of this project as follows:

- 239,000 patient visits in DY 3
- 246,000 patient visits in DY 4
- 258,000 patient visits in DY 5

Memorial expects approximately 5-10% of these patients, or 12,000 to 25,800 patient visits, will be Medicaid or indigent.

Category 3 outcomes: IT-1.10 Diabetes care: HBA1c poor control (>9.0%)
**Project Option – 1.1.1 Establish more primary care clinics: Physician Network Development**

**Unique RHP Project Identification Number:** 137805107.1.1

**Performing Provider Name/TPI:** Memorial Hermann Hospital (Memorial)/137805107

**Project Description:** In this project, Memorial will expand the network of primary care physicians in the community. Texas has a growing shortage of primary care doctors and nurses due to the needs of an aging population, a decline in the number of medical students choosing primary care, and thousands of aging baby boomers who are doctors and nurses looking towards retirement. The shortage of primary care workforce personnel in Texas is a critical problem that can be addressed under this Waiver. The shortage of primary care providers has contributed to increased wait times in hospitals, community clinics, and other care settings. Expanding primary care clinics will increase access and capacity and help create an organized structure of primary care providers, clinicians, and staff. Moreover, this expansion will strengthen an integrated health care system and play a key role in implementing disease management programs. A greater focus on primary care will be crucial to the success of an integrated health care system.

**Goal(s) and relationship to Regional goal(s):**

Project goals:

Expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.

This project meets the following Region 3 goals:

This project addresses the RHP’s goal to “[i]ncrease access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.”

**Challenges and how addressed:**

This project faces three key challenges. First, Memorial must raise awareness and change existing patterns for seeking health care services for some patients. A second challenge is to raise awareness for the service delivery model offered by these new sites so that patients who currently don’t have access to after-hours care learn that this type of care is available through a physician’s clinic rather than turning to emergent or urgent care clinics. And finally, recruiting 60 providers within four years in this competitive environment will be a challenge. Memorial will address these challenges by implementing other projects with reduce inappropriate ED use, educating patients on the benefits of primary care, and aggressively recruiting primary care providers.
5-year expected outcome for provider and patients:
Memorial will aim to recruit 60+ new primary care providers over the course of the Waiver. In addition, eighteen new primary care locations are planned to address patient access issues described above. These locations have been identified to reach people living across the Houston community including Downtown, Katy, the Inner Loop, and Clear Lake as examples. The clinics are scheduled to come on line during the course of the next four years providing easy access with early morning and after hours services along with weekend availability. These sites are estimated to provide new primary care capacity for 150,000 people.

Starting Point/Baseline: Memorial has identified the sites to expand primary care clinics.

Rationale:

Reasons for selecting the project option: In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively (comparable ratios for US total are 219.5 and 90.5, respectively). From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Therefore, there is a significant need to expand primary care in order to facilitate delivery system reform.

In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Unique community need identification number the project addresses:
CN1 – Primary Care

How the project represents a new initiative for Performing Provider or significantly enhances an existing delivery system reform initiative:
This project represents a significant improvement in Memorial’s ability to deliver primary healthcare; which has a significant deficiency in Regions.

Related Category 3 Outcome Measure(s): IT-1.10 Diabetes care: HBA1c poor control (>9.0%)
Reasons/rationale for selecting the outcome measure(s):

If patients are getting timely patient care, appointments, and information then their satisfaction will increase. Therefore, patient satisfaction is an is a reasonable metric by which to judge the effectiveness of this project.

Relationship to Other Projects: This project is part of Memorial’s larger plans to expand and develop primary care and specialty care services, while improving access to care. Expanding primary care supports/reinforces several of the Category 1 and 2 projects: Increasing the number of physicians rotating through the primary care residency program will have a direct impact on Expanding Primary Care Capacity (1.1); this project not only will increase the number of available physicians to participate in medical homes (2.1), it will also ensure that they are trained in the medical home concept; finally, the medical home concept of this training program also reinforces the Redesign of Primary Care (2.3), the Redesign to Improve the Patient Experience (2.4).

Relationship to Other Performing Providers’ Projects in the RHP: TBD

Plan for Learning Collaborative: Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system

Project Valuation:

Approach for valuing project: The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

Rationale/justification for valuation: The recruitment and expansion of primary care clinics and physicians will help address a substantial need in the community for increased access to primary care. It will also go a long way towards achieving the Waiver goal of improving outcomes while curbing the risk of healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes.
| Year 2 | (10/1/2012 – 9/30/2013) | Milestone 1  
P-X: Establish baseline for existing primary care clinic volume, number of primary healthcare workers and staff, and patient satisfaction in similar clinical settings in the community. 
Metric  
Establish baseline for future years.  
Data Source:  
Submission of documentation demonstrating study of baseline numbers.  
Goal:  
To determine baseline for measure of project improvement in future years. 

**Milestone 2**  
CQI: P-1 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects  

| Year 3 | (10/1/2013 – 9/30/2014) | Milestone 3  
P-1: Establish additional/expand existing/relocate primary care clinics.  
Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space.  
Baseline/Goal: Increase by 3 clinics.  
Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider.  

**Milestone 4 [P-5]**: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers.  
Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites.  
Baseline/Goal: 5% increase over DY 2 baseline. (approximately 246,000 visits)  
Data Source: Registry, EHR, claims, or other Performing Provider source.  

| Year 4 | (10/1/2014 – 9/30/2015) | Milestone 5  
I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.  
Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.  
Baseline/Goal: 5% increase over DY 2 baseline. (Approximately 258,000 visits)  
Data Source: Registry, EHR, claims, or other Performing Provider source.  

| Year 5 | (10/1/2015 – 9/30/2016) | Milestone 8  
I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.  
Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.  
Baseline/Goal: 10% increase over DY 2 baseline. (Approximately 258,000 visits)  
Data Source: Registry, EHR, claims, or other Performing Provider source.  

| Milestone 9 [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers.  
Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites.  
Baseline/Goal: 15% increase over DY 2 baseline. (Approximately 82 providers total)  
Data Source: Documentation of completion of all items described by the RHP plan for this measure; hospital or
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric</strong></td>
<td>P-1.1 Number meetings, conference calls or webinars organized by the RHP that the provider participated in.</td>
<td>DY 2 baseline.</td>
<td>other Performing Provider report, policy, contract, or other documentation.</td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
<td>Data Source: Documentation of completion of all items described by the RHP plan for this measure; hospital or other Performing Provider report, policy, contract, or other documentation.</td>
<td>Data Source: Documentation of completion of all items described by the RHP plan for this measure; hospital or other Performing Provider report, policy, contract, or other documentation.</td>
<td>Milestone 10 [I-11]: Patient satisfaction with primary care services.</td>
</tr>
<tr>
<td><strong>Milestone 7 [I-11]</strong></td>
<td>Patient satisfaction with primary care services.</td>
<td>Metric [I-11.2]: Percentage of patients receiving survey. Specifically, the percentage of patients that are provided the opportunity to respond to the survey. Demonstrate improvement over prior reporting period.</td>
<td>Baseline/Goal: 10% improvement. (Ultimate goal is to achieve a patient satisfaction score in approximately the 75 percentile)</td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong></td>
<td>5% improvement.</td>
<td>Data Source: Performing provider documentation of survey distribution; EHR.</td>
<td>Data Source: Performing provider documentation of survey distribution; EHR.</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Milestone Bundle Amount:</strong> $3,974,956</td>
<td><strong>Year 3 Estimated Milestone Bundle Amount:</strong> $4,336,461</td>
<td><strong>Year 4 Estimated Milestone Bundle Amount:</strong> $4,349,067</td>
<td><strong>Year 5 Estimated Milestone Bundle Amount:</strong> $3,592,708</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>137805107.3.1</td>
<td>IT-1.10</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>----------------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>Diabetes Care : HbA1c poor control (&lt;9.0%) - NQF 0059 Stand Alone Measure</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $16,253,190
**Project Option:** 1.13.1 Develop and Implement Crisis Stabilization Services  
**Performing Provider:** Memorial Hermann Hospital/TPI 137805107  
**Unique Project ID:** 137805107.1.2

- **Provider:** Memorial Hermann Hospital (Memorial) is an 860 bed hospital located in Houston, TX and is part of the Houston-Sugarland-Baytown MSA. The MSA population served by Memorial is approximately 6,000,000 people.

- **Intervention(s):** Memorial will develop a crisis stabilization clinic that would provide rapid access to initial psychiatric treatment and outpatient services. The goal is to identify consumers with behavioral health needs that can be addressed and avoid unnecessary use of emergency departments, hospitalization or incarceration.

- **Need for the project:** From 2007-2012, Emergency Psych volumes coming into Memorial’s acute care hospitals that could have been treated at a lower level of care was approximately 22,000 patients. Of that number, 11% (7,400) of those patients could have been discharged immediately if an emergency appointment with a psychiatrist or mental health nurse practitioner were rapidly available (within 24 hours). This project will place an accessible crisis alternative in four areas (4 clinics) of the community to target this underserved population.

- **Target population:** The target population is emergent psychiatric patients coming into Memorial’s acute care facility. A crisis clinic would provide rapid access to initial psychiatric treatment and outpatient services to a large volume community jointly in need of investment in mental health services. It is estimated that 20% of people in Harris County suffer from behavioral health issues of which 25% are uninsured and another 18% or 701,559 are covered by Medicaid. Of the 701,559 residents covered by Medicaid, approximately 8% have received some type behavioral health treatment.

- **Category 1 or 2 expected patient benefits:** The establishment of these behavioral health services will decrease emergency department visits by behavioral health patients through increasing bed availability for acute patients, decrease emergency department wait times which cause emergency department bottleneck; decrease unnecessary admissions to inpatient behavioral programs and/or county juvenile and judicial systems. Over the course project Memorial expects to provide approximately 9200 patient visits as a result of this project as follows:

  700 patient visits in DY 3 (one clinic operating)  
  3100 patient visits in DY 4 (2 clinics operating)  
  5400 patient visits in DY 5 (4 clinics operating)

Memorial expects approximately 60% of these patients to be on Medicaid and approximately 35% of these patients to be indigent.
• **Category 3 outcomes:** IT 3.8 – By DY5, Memorial expects to demonstrate an improvement on its Behavioral Health/Substance Abuse 30 day readmission rate by at least 10% over baseline measurement.
Project Option-1.13.1 Develop and Implement Crisis Stabilization Services  
Unique RHP Project Identification Number: 137805107.1.2

Performing Provider Name/TPI: Memorial Hermann Hospital (Memorial)/TPI 137805107

Project Description:

Memorial’s proposal is to develop a crisis stabilization clinic that better identifies people with behavioral health needs, responds to those needs and links persons with the most appropriate level of care. Our goal is to keep individuals healthy and safe, develop processes and intervention to manage challenging behaviors, and avoid unnecessary use of emergency departments, hospitalization or incarceration. The clinic will be staffed with a nurse practitioner, social worker and other patient care staff to provide an outpatient emergency appointment for patients with no immediate access for mental health care.

The clinic will use a short-term treatment model to reduce acute symptoms of mental illness provided in a secure and protected clinically staffed, psychiatrically supervised, treatment environment.

The target population will be emergent psychiatric patients coming into Memorial’s acute care facility. From 2007-2012, Emergent Psych volumes coming into Memorial Hermann Health System’s acute care hospitals that could have been treated at an lower level of care was approximately 22,000 patients. Of that number, 11% (2400) of these patients could have been discharged from the hospitals immediately if an emergency appointment with a psychiatrist or mental health nurse practitioner were rapidly available (within 24 hours). A Crisis Clinic would provide rapid access to initial psychiatric treatment and outpatient services to a large urban community greatly in need of investment in mental health services.

Further analysis will be completed to assess the behavioral health needs of patient currently receiving crisis services in the jails, other area emergency departments or psychiatric hospitals. A gap analysis will be used to develop a data-driven plan for specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients. A complete review of potential crisis alternative service models will be explored to determine acceptable and feasible models for implementation of this program. The clinic will develop a setting where access to behavioral healthcare is available to the community beyond the traditional hours of private providers. This setting would most appropriately assess and treat mental health consumers at the moment of crisis. This would remove a layer of emergency services which, in its current state, only provides a referral to appropriate care once the imminent crisis has passed. Providing an appropriate setting and access to care for behavioral health consumers in crisis, staffed with appropriately licensed professionals, provides a community resource that efficiently responds to these crises and reduces the number of visits to emergency departments for behavioral health conditions. This project will place an accessible crisis alternative in four areas of the community to target this underserved population.
Goal(s) and relationship to Regional goal(s):

Project goals:

Promote better health outcomes for behavioral health patients. Decrease unnecessary ED visits. Decrease unnecessary admissions and readmissions. The goal of this project is to establish a crisis clinic to broaden access to behavioral healthcare that may include the building of a new facility or expansion of operating hours in a select number of clinics capable of treating this particular patient population.

This project meets the following Region 3 goals:

This project addresses the RHP’s goal to “[i]ncrease access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.”

Challenges:

Individuals with chronic mental health conditions struggle with non-compliance in prescribed health maintenance activities, including medicine management, follow-up, and Medicaid enrollment active. Memorial also anticipates the challenge of recruiting competent behavioral healthcare staff to work non-traditional hours. Memorial will address these challenges by focusing on patient education and making the patient the center of care decisions to the fullest extent possible. Additionally, Memorial will engage in aggressive recruitment to locate and hire professional staff.

5-year expected outcome for provider and patients:

With the addition of behavioral health crisis services to the current programs offered at Memorial, we expect to decrease emergency department visits by behavioral health patients thus increasing bed availability for acute patients; decrease emergency department wait times which cause emergency department bottlenecks; decrease unnecessary admissions to inpatient behavioral health programs and or county jails/judicial systems. All of these situations will result in a significant cost savings for area hospitals, local mental health authorities and county justice organizations. Most importantly, behavioral health patients will receive necessary treatment in a more efficient and timely manner.

Starting Point/Baseline: Currently, Memorial does not have a crisis clinic available to patients with mental healthcare needs.

Rationale:

A Behavioral Health Crisis Clinic would provide an efficient portal for outpatient stabilization and comprehensive Behavioral Health Social Work services. This would ensure patients with chronic or emergent needs are connected to comprehensive Behavioral Health Services and are provided with an outpatient crisis follow-up resource for future events in place for system acute care hospitals. Patients will meet with a licensed Clinical Social Worker in the Behavioral Health
Crisis Clinic to develop a comprehensive Behavioral Health treatment plan, be educated about navigating the fragmented Behavioral Health/Mental Health care delivery system, and if appropriate set up a case management relationship to address compliance issues with health maintenance activities for a 90 period. After 90 days, patient will be reevaluated for compliance with community providers and/or on-going case management services.

In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Project components:

a) Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps

- Memorial will conduct baseline focus groups with local Behavioral Health Providers, local planning/advisory councils and county mental health authority.

b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.

- Memorial will examine the current service delivery system, determining the availability of persons in need and also determining adequacy or limitations of services for persons in need.

- Memorial will review the current state of the available mental health workforce, including community based and hospital inpatient services.

c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients.

- Memorial will utilize social indicators and prevalence data on the general population related to mental health risk factors, estimate the need for services.
- Memorial will develop an on-going data collection system/process that Leadership will utilize to update the services currently available and compare with services needed (Gap Analysis.)

d) Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.

- Memorial will analyze the differences in profiles between those receiving services and those not receiving services.

e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

- Memorial will develop an on-going data collection system/process that Leadership will utilize to update the services currently available and compare with services needed (Gap Analysis.)

- Memorial will recommend and prioritize steps to strategically enhance services to achieve the greatest impact on mental health service needs and system development on an ongoing basis.

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

- CN.1 - Primary Care
- CN.8 - High rates of inappropriate emergency department utilization
- CN.9 - High rates of preventable hospital readmissions
- CN.6 - Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, and elderly

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

This project would significantly enhance Memorial’s ability to deliver vital healthcare services. Our community does not currently have sufficient resources to deal with the needs of the behavioral healthcare population and this project would directly address that deficiency. The patients at our facilities would demonstrably benefit from such a project. Emergent Psychiatric volumes which entered our acute care facilities from 2007-2012 that potentially could have been managed outpatient from 2007-2012 was approximately 61%, or over 22,000 patient encounters. Close to 2,500, or 11% of these patient encounters could have been discharged immediately from the system if an emergency appointment with a psychiatrist or nurse practitioner within 24 hours was rapidly available.

**Related Category 3 Outcome Measure(s):** OD-3 Potentially Preventable Readmissions; IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate
Reasons/rationale for selecting the outcome measure(s):

When patients with behavioral healthcare needs are receiving the correct treatment in the correct setting this will improve their health outcomes and significantly reduce the amount of potentially preventable readmissions for these patients.

Relationship to other Projects: This project is part of Memorial’s larger vision to expand and develop primary and specialty care services, while improving access to care and implementing delivery improvements targeted to specific populations (in this case, behavioral health patients). In the current state of fragmented healthcare delivery, Behavioral Health consumers are left to navigate primary care systems that do not provide behavioral health treatment and are not staffed with behavioral health professionals trained to meet the needs of this targeted population. This project develops a resource staffed with Behavioral Health Professionals to meet the needs of these patients without burdening ERs with a population they are not equipped to treat. The current state drives up inappropriate ED utilization and costs for all consumers of primary care.

Relationship to Other Performing Providers’ Projects in the RHP: TBD

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

Project Valuation:

Approach for valuing project: The valuation of Memorial’s projects use a method which ranks the importance of each projects based several key factors. First, Memorial considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, Memorial considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, Memorial reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

Rationale/justification for valuation: A crisis clinic will significantly reduce unnecessary hospital readmissions and thereby increase the efficient allocation of resources in Region 3. Furthermore,
the crisis stabilization center will add a much needed component to the healthcare infrastructure in the community, thus meeting one of the three main goals of the waiver. Approximately, 22,000 patients each year come into Memorial’s acute care facilities when they could have been treated at a lower level of care. Of that number, 11% (7,400) could have been discharged immediately if an emergency appointment with a psychiatrist or mental health nurse practitioner were rapidly available (within 24 hours). This project will place an accessible crisis alternative in four areas (4 clinics) of the community to target this underserved population. This project directly targets mental health, which is a significantly underserved public health issue in the state and in Region 3 specifically. Furthermore, the project will significantly reduce the cost of treating mental health patients by providing care in a more appropriate setting and avoiding unnecessary hospitalization. Lastly, this project will increase the quality and availability of mental health services in the community and improve patient quality of life.
<table>
<thead>
<tr>
<th>137805107.1.2</th>
<th>1.13.1</th>
<th>A-E</th>
<th>DEVELOP AND IMPLEMENT CRISIS STABILIZATION SERVICES TO ADDRESS THE IDENTIFIED GAPS IN THE CURRENT COMMUNITY CRISIS SYSTEM: HEALTH CRISIS CLINIC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Memorial Hermann Hospital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Outcome Measure(s):**

<table>
<thead>
<tr>
<th>Related Category</th>
<th>137805107.3.2</th>
<th>IT-3.8</th>
<th>Behavioral Health /Substance Abuse 30 day readmission rate</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1**
P-1 Milestone: Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health services providers.

**Metric 1**
P-1.1 Metric: Number of meetings and participants.

**Data Source:** Attendance lists

**Goal:** Convene stakeholders.

**Milestone 1 Estimated Incentive Payment:** $1,349,984

**Milestone 2**
[P-X] Establish baseline for inappropriate ED utilization, and measure of appropriate crisis alternatives.

**Metric**

Establish baseline for future years.

**Data Source:** Submission of

**Milestone 4**
P-5 Milestone: Develop administration of operational protocols and clinical guidelines for crisis services.

**Metric**
P-5.1: Completion of policies and procedures.

**Data Source:** Internal policy and procedures documents and operations manual.

**Goal:** Better operations of project

**Milestone 4 Estimated Incentive Payment:** $1,472,760

**Milestone 5**
P-2: Identify licenses, equipment requirements and other components needed to implement and operate options selected.

**Milestone 8**
CQI [P-1.1]: Participate in at least quarterly interactions (meetings, conference call or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects

**Metric**
P-1.1 Number of quarterly meetings, conference calls or webinars organized by the RHP that the provider participated in.

**Data source:** Documentation of quarterly meetings, conference calls, or webinars including agendas for phone calls, slides from webinars and/or meeting notes.

**Goal:** Investment in learning and sharing of ideas is central to improvement.

**Milestone 8 Estimated Incentive Payment:** $2,215,563

**Milestone 9**
I-12: Utilization of appropriate crisis alternatives.

**Metric**

1 I-12.1: Goal: 15% increase in utilization of appropriate crisis alternatives.

**Data source:** Claims, encounter and clinical record data.

**Rationale:** see project goals.

**Milestone 10 Estimated Incentive Payment:** $1,830,248

**Milestone 11**
CQI [P-1.1]: Participate in at least quarterly interactions (meetings, conference call or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects

**Metric**

I I-12.1: Goal 10% increase

**Data source:** Documentation of quarterly meetings, conference calls, or webinars including agendas for phone calls, slides from webinars and/or meeting notes.

**Rationale:** see project goals.

**Milestone 11 Estimated Incentive Payment:** $1,830,248

**Milestone 12**
I-12: Utilization of appropriate crisis alternatives.
### Develop and Implement Crisis Stabilization Services to Address the Identified Gaps in the Current Community Crisis System: Health Crisis Clinic

**Memorial Hermann Hospital**

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

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| Paperwork demonstrating study of baseline numbers. | **Goal:** To determine baseline for measure of project improvement in future years. | **Milestone 5 Estimated Incentive Payment:** $1,472,760 | **Metric 1 P-1.1 Number of quarterly meetings, conference calls or webinars organized by the RHP that the provider participated in.**
| **Goal:** Better project operations | **Milestone 6:** Process P-4: Hire and train staff to operate and manage projects selected | **Data source:** Written plan | **Data source:** Documentation of quarterly meetings, conference calls, or webinars including agendas for phone calls, slides from webinars and/or meeting notes.**
| **P-2.1: Project plan.** | **Metric P-4.1: Number of staff secured and trained.** | **Goal:** Better project operations | **Goal:** Investment in learning and sharing of ideas is central to improvement.**
| **Data Source:** Written plan | **Data Source:** Project records; Training curricula as developed in P-2. | **Milestone 6 Estimated Incentive Payment:** $1,472,760 | **Milestone 10 Estimated Incentive Payment:** $1,830,247**
| **Goal:** Better project operations | | | **Rationale:** see project goals.**
| **Milestone 3 Estimated Incentive Payment:** $1,349,984 | **Milestone 7:** P-7: Participate in at least quarterly interactions (meetings, conference call or webinars) with other providers and the RHP to promote collaborative learning around shared or similar in utilization of appropriate crisis alternatives. | **Milestone 9 Estimated Incentive Payment:** $2,215,562.**
| **Milestone 3** P-2: Conduct mapping and gap analysis of current crisis system. | **a. Numerator:** Number of people receiving community behavioral healthcare services from appropriate crisis alternatives | | **Metric 1 P-1.1 Number of quarterly meetings, conference calls or webinars organized by the RHP that the provider participated in.**
| **Metric 2** P-2.1 Metric: Produce a written analysis of community needs for crisis services. | **b. Denominator:** Number of people receiving community behavioral health services in this project. (Approximately 3100 patient visits) | | **Data source:** Claims, encounter and clinical record data.**
| **Data Source:** Written plan | **Data source:** Claims, encounter and clinical record data. | | **Rationale:** see project goals.**
| **Goal:** Better information to reach targeted patients | **Rationale:** see project goals. | | **Milestone 9 Estimated Incentive Payment:** $2,215,562.**
| **Milestone 3 Estimated Incentive Payment:** $1,349,984 | **Milestone 6 Estimated Incentive Payment:** $1,472,760 | | **Milestone 10 Estimated Incentive Payment:** $1,830,247**

---

**Regional Healthcare Partnership Plan Region 3** 334
**DEVELOP AND IMPLEMENT CRISIS STABILIZATION SERVICES TO ADDRESS THE IDENTIFIED GAPS IN THE CURRENT COMMUNITY CRISIS SYSTEM: HEALTH CRISIS CLINIC**

**Memorial Hermann Hospital**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>137805107.3.2</th>
<th>IT-3.8</th>
<th>Behavioral Health/Substance Abuse 30 day readmission rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td>projects</td>
</tr>
<tr>
<td><strong>Metric 7 P-7-1</strong> Number of quarterly meetings, conference calls or webinars organized by the RHP that the provider participated in.</td>
<td></td>
<td></td>
<td>Data source: Documentation of quarterly meetings, conference calls, or webinars including agendas for phone calls, slides from webinars and/or meeting notes.</td>
</tr>
<tr>
<td><strong>Goal:</strong> Investment in learning and sharing of ideas is central to improvement.</td>
<td></td>
<td></td>
<td>Milestone 7 Estimated Incentive Payment: $1,472,760</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Milestone Bundle Amount:</strong> $4,049,953</td>
<td><strong>Year 3 Estimated Milestone Bundle Amount:</strong> $4,418,281</td>
<td><strong>Year 4 Estimated Milestone Bundle Amount:</strong> $4,431,125</td>
<td><strong>Year 5 Estimated Milestone Bundle Amount:</strong> $3,660,495</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $16,559,854
**Project Option: 1.1.1 - 1.1 Expand Primary Care Capacity: Pediatric Clinic Expansion – North Harris County Pediatric Clinic**

**Unique Project ID:** 137805107.1.3  
**Performing Provider Name/TPI:** Memorial Hermann Hospital/ 137805107

**Project Summary:**

Provider: Memorial Hermann Hospital (Memorial) is an 860 bed hospital located in Houston, TX and is part of the Houston-Sugarland-Baytown MSA. The MSA population served by Memorial is approximately 6,000,000 people.

**Intervention(s):** Memorial will establish the North Harris County Pediatric Clinic which will provide primary care for pediatric patients in that area of Harris County. Memorial will contract UTHSC-H to provide physician services to complement Memorial’s investment in new technology, equipment and space to better provide pediatric services.

**Need for the project:** Prospective pediatric patients in the targeted service area described below currently face many roadblocks to adequate primary care including economic burdens, language barriers and lack of knowledge for seeking pediatric care. Due to the shortage of primary care providers in the community, the average wait period for a primary care appointment is 17 days, which results in increased reliance on hospital EDs for primary care and non-emergent care. The project will increase the percentage of patients who receive appropriate primary care including preventative services and regular monitoring for patients with chronic illnesses.

**Target population:** The target population is uninsured and underinsured children in the area of Harris County that is between Cypress Parkway and FM 1960 to the North, Tomball Parkway to the West, West Road to the South and Hwy. 59N to the East. This area encompasses 15 census tracts with a total of over 15,000 children living below the federal poverty level, who are on Medicaid, or would be eligible for Medicaid. It is estimated that 38.4% of the patients in the service area for this clinic are either uninsured or underinsured children and rely on Memorial Hermann’s and other hospitals’ emergency departments for primary care services.

**Category 1 or 2 expected patient benefits:** The clinic will provide a more appropriate setting for pediatric primary care for the target population. They will benefit primarily from better access to primary care and better management of illness and chronic conditions. The clinic is expected to be running at capacity (a conservatively estimated rate of approximately 15,000 patient visits per year) by July of DY4 and we expect to have provided a total of approximately 36,000 patient visits DY3-DY5. It is expected that 60% of these will be Medicaid/Medicaid-eligible patients (21,600).

**Category 3 outcomes:** IT-1.20 Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Standalone)—Increase the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months as measured by the Asthma Therapy Assessment Questionnaire (ATAQ).
Project Option 1.1.1- Establish More Primary Care Clinics: Pediatric Clinic Expansion -
North Harris County Pediatric Clinic

Unique RHP Project Identification Number: 137805107.1.3

Performing Provider Name/TPI: Memorial Hermann Hospital (Memorial)/137805107

Project Description: Using the strengths developed during their longstanding partnership,
Memorial and The University of Texas Health Science Center at Houston (UTHSC-H) intend to
work together to address the shortage of pediatric primary and specialty care in Region 3. In this
project, Memorial will establish the North Harris County Pediatric Clinic, which will provide
primary care for pediatric patients in an area of Harris County that is between Cypress Pkwy and
FM 1960 to the north, Tomball Parkway to the west, West Road to the south, and Highway 59N
to the east. Memorial has defined the service area for this clinic as a priority area for pediatric
services, because it contains 15 of the 81 census tracts that make up the top 10% of all census
tracts in Harris County with the greatest number of people below the age of 18 that are living
below the federal poverty level (FPL). (The census tracts are 5511, 5506.03, 5503.02, 5503.01,
5502, 5501, 5338.02, 2415, 2408.01, 2407.01, 2405.02, 2227, 2226, 2225.03, and 2225.01.) The
number of children living below the FPL in these 15 census tract areas is estimated to be
approximately 15,465, who would either be on Medicaid, or are Medicaid-eligible. This clinic
will market services to this population and provide services to those who respond. The capacity
of the clinic is expected to be over 15,000 patient visits per year. Using a very conservative
estimate of 50% of these clinic visits being with Medicaid/Medicaid-eligible patients, we would
see a total of at least 7,500 Medicaid primary care visits per year. (UT Physicians’ current payer
mix for pediatrics includes a 60% mix of Medicaid and non-resource.) We estimate that we will
have provided 36,000 patient visits by the end of DY5, with approximately 21,600 of them being
for patients on Medicaid, or who are Medicaid-eligible (using UT Physicians’ current rate of
Medicaid/Medicaid-eligible pediatric patients). Furthermore, these areas have particularly high
numbers of Hispanics (49.9%), for whom language, as well as poverty, may pose a barrier to
obtaining primary care for their children. Black/African Americans, another segment of the
population that tend to be medically underserved, also make up a significant proportion of the
population in these census tracts (35.1%). The service area for this clinic includes large
populations with economic, cultural, language, and transportation barriers to receiving primary
care. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics
are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1:
2010 Poverty and Median Income Estimates - Counties.) In order to address the unique needs of
different communities in the greater Houston area, Memorial has chosen to establish a pediatric
clinic in this area as an independent DSRIP project.

Using their longstanding partnership to provide quality healthcare as a base, Memorial will
contract UTHSC-H to provide physician services to complement Memorial’s investment in new
technology, equipment and space to better provide pediatric services. Specifically, UTHSC-H
will redirect pediatricians already on its staff who have the capacity to care for additional patients, recruit additional pediatricians, or increase residency programs to fill the need for additional pediatric specialists. UTHSC-H is uniquely positioned to attract and retain new physicians due to its accomplishments as a world-class academic and research institution. This additional service line will avoid duplication and draw on the strength of UTHSC-H’s academic presence in the field of pediatric medicine, and will also benefit Memorial by increasing the quantity, quality, and scope of services provided at its facilities.

Practically, Memorial will subcontract with UTHSC-H to provide physician and other services needed to implement this project. For example, Memorial will lease additional space to open the North Harris County clinic. This space will include additional consulting, exam and procedure rooms. Memorial will also subcontract with UTHSC-H to provide primary care providers and support staff to operationalize the project. For all services in which UTHSC-H is a subcontractor, Memorial will pay an agreed rate that is set in advance and represents fair market value for services negotiated in the ordinary course of business through an arms-length transaction.

**Goal(s) and relationship to Regional goal(s):**

**Project goals:**

Expand the capacity of pediatric primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that pediatric patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.

This project meets the following Region 3 goals:

One of the goals of the region is to “Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay”. Expansion of primary care capacity certainly relates to this goal as it will make it easier for Memorial to provide care to underserved populations.

**Challenges and how addressed:**

This project faces three key challenges. First, Memorial must raise awareness and change existing patterns for seeking health care services for some patients. A second challenge is to raise awareness for the service delivery model offered by these new sites so that patients who currently don’t have access to after-hours care learn that this type of care is available through a physician’s clinic rather than turning to emergent or urgent care clinics. And finally, recruiting additional primary care providers and pediatric specialists in this competitive environment will be a challenge. Memorial will address these challenges by implementing other projects to reduce inappropriate ED use, educating patients on the benefits of primary care, and aggressively
recruiting primary care providers by offering competitive salaries and other incentives to practice in the outlying clinics.

**5-year expected outcome for provider and patients:**

There will be shortening of waiting times for primary pediatric care appointments and increased uptake of primary pediatric care services in this specific service area, which will increase the percentage of patients who receive appropriate primary health care, including preventative services and regular monitoring for those patients with chronic illnesses. In total, we expect to provide primary care visits totaling over 15,000 per year, once the clinic is running at capacity. Since this clinic will serve an area with a high rate of children living below poverty, we expect that at least 7,500 of these patient visits per year will be from the Medicaid/Medicaid-eligible population. We expect to have provided a total of approximately 36,000 patient visits DY3-DY5, with approximately 21,600 of them being Medicaid/Medicaid-eligible patients.

**Starting Point/Baseline:** Memorial has identified the targeted service area needing increased access to pediatric primary care. Since this will be a new clinic, the baseline will have to be established during DY3.

**Rationale:**

In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively (comparable ratios for US total are 219.5 and 90.5, respectively). From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Therefore, there is a significant need to expand primary care in order to facilitate delivery system reform.

Research has shown that access to primary care is associated with better health outcomes at less cost. Access to primary care ensures better preventive care and better management of chronic disease, with lack of access often resulting in more expensive care, received in hospitals and emergency departments (ED). For the fiscal year 2010, 10% of all potentially preventable hospitalizations (PPR) were ambulatory care sensitive. In 2009, 41% (390,945) of ED visits in Houston were primary care related (PCR), including non-urgent, primary care treatable, and primary care preventable, and for 26.8% (104,762) of these PCR visits, Medicaid was the payor. Getting more patients into primary care will help to reduce the use of this more costly care. Placing more primary care providers out in the communities will help to address transportation access barriers and the expansion of clinic service hours will provide a greater selection of available appointment times. By increasing primary care capacity, engaging more people in the primary care system, and avoiding inappropriate utilization of costly services, the community will experience better health outcomes and greater patient satisfaction.¹

In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Because UTHSC-H will IGT on behalf of Memorial for its successful implementation of delivery system improvements under the Waiver, this structure results in a payment from a private hospital to an entity that provides its IGT, which arguably raises questions regarding provider donations. Nonetheless, this collaboration is the most effective and efficient structure to expand access to pediatric services to the community, and ensure overall improvement to the Region 3 delivery system. This collaboration is a natural progression of the existing relationship and the clinical strengths of Memorial and UTHSC-H. Memorial is the largest not-for-profit healthcare system in Texas and serves the greater Houston community through 12 hospitals, a vast network of affiliated physicians and numerous specialty programs and services. With over 4,000 medical staff members, 26 residency programs, 48 fellowship programs, and over 1,300 physicians in training, Memorial is dedicated to providing high quality health services in order to improve the health of the people in Southeast Texas. The mission of UTHSC-H is to educate health science professionals, discover and translate advances in the biomedical and social sciences, and model the best practices in clinical care and public health. UTHSC-H strives to improve the health of the public in the State of Texas through educating future public health practitioners and bringing evidence based public health practices to Texas. UTHSC-H’s faculty of over 900 physicians in 80 specialties provide comprehensive care for patients while teaching 800 medical students and over 900 residents in over 60 accredited residency/fellowship programs.

**Core Components:**

Through the new North Harris County Pediatric Clinic, we propose to:

a) Memorial will identify and lease appropriate space within the defined service area to establish the new clinic that includes reception, consulting, exam and procedure rooms, and will provide the necessary equipment and furnishings.
b) UT Physicians will be contracted at fair market value to provide primary care physicians, advanced practice providers, and support staff to operate the clinic.

c) In addition to regular business hours, the clinic will operate with expanded evening and Saturday hours to increase access for individuals that are not able to leave their jobs for healthcare appointments, and to provide care for those needing urgent care services that can be accommodated in a primary care clinic.

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

CN1 – Primary Care

CN8 – High rates of inappropriate emergency department utilization

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

This project represents a significant improvement in Memorial’s ability to deliver primary healthcare to babies, children, and adolescents. This new initiative proposes to add space, providers, support staff, and extended service hours in a location where economic and cultural barriers to receiving appropriate healthcare are indicative of a need for services that are conveniently located and available when needed. This project is an expansion of services in order to improve access to care.

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

OD-1 Primary Care and Chronic Disease Management: IT-1.20 Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Non-Standalone)

Increase the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months as measured by the Asthma Therapy Assessment Questionnaire (ATAQ). The ATAQ was found to have “good internal consistency and strong relationships with existing validated measures of childhood health status, asthma impact, and health care utilization.” The score range on the 7-item ATAQ is 0-7, with 0 showing complete control and each score of 1 thereafter indicating an area in need of improved management. The ATAQ will be administered at each patient visit for patients with a diagnosis of asthma. Improvement is defined as a downward trend in the total score for the 7-items on the ATAQ for each individual patient.


5 Ibid.
OD-1 Primary Care and Chronic Disease Management: IT-1.1 Third next available appointment (Non-standalone measure)

Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

OD-9 Right Care, Right Setting: IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381273 (Standalone measure)

Numerator: Percentage of clinic patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period. Denominator: Denominator is all clinic patients age two through age 18, diagnosed with asthma during the measurement period. The denominator will include recipients with claims with asthma as primary or secondary diagnoses with the dates of service being within the measurement period.

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

Asthma is one of the most common chronic illnesses among children in the U.S. The National Health Interview Survey (2011) found that 14% of all children living in the U.S., 21% of non-Hispanic black children, and 18% of children in poor families had ever been diagnosed with asthma. The number of children residing in the defined service area for this clinic is estimated at over 35,000, with 35% of those being non-Hispanic black (over 12,000) and 43.7% living below the federal poverty level (over 15,000). (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties.) By extrapolating the U.S. statistics on children with asthma to the service area for this clinic, we can conservatively estimate that there are at least 4,900 children in this area suffering from asthma. Since the service area for this clinic has a high proportion of children living below the federal poverty level and a high proportion of non-Hispanic black children, achieving better asthma control for these patients will be an important and worthy outcome measure of increasing access to primary care services for children.

After the assessment of severity for the initial diagnosis, the goal then becomes asthma control, demonstrated through symptom manifestation and disease activity. The use of the ATAQ itself has benefits beyond simple measurement—it is a tool to ensure regular assessment and the

---


consistent questioning can teach children and/or their parents which symptoms and experiences should be anticipated for managing their asthma.\textsuperscript{8}

By increasing access to primary care and providing education and support in gaining control over asthma, the project has the potential to prevent the acute worsening of the illnesses, thereby decreasing the need for emergency care. Hence ED visits for asthma will be a good outcome measure for this project. Finally, patients are more likely to arrive for their appointments when they are able to get them when needed and when most convenient. Consequently, we will be measuring third next available appointment as a measure of increased access to primary care services.

**Relationship to Other Projects:** This project is part of Memorial’s larger plans to expand and develop primary care and specialty care services, while improving access to care. Expanding primary care supports/reinforces several of the Category 1 and 2 projects: increasing the number of physicians rotating through the primary care residency program will have a direct impact on Expanding Primary Care Capacity (1.2); this project not only will increase the number of available physicians to participate in medical homes (2.1), it will also ensure that they are trained in the medical home concept; this project reinforces the Redesign of Primary Care (2.3), the Redesign to Improve the Patient Experience (2.4).

**Relationship to Other Performing Providers’ Projects in the RHP:** Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

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

**Project Valuation:** The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the

\textsuperscript{8} Barbara P. Yawn, Susan K. Brenneman, Felicia C. Allen-Ramey, Michael D. Cabana and Leona E. Markson. Assessment of Asthma Severity and Asthma Control in Children. Pediatrics 2006;118;322
The magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

The expansion of primary care clinics will help address a substantial need in the community for increased access to primary care. It will also go a long way towards achieving the Waiver goal of improving outcomes while curbing the risk of healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Memorial Hermann Hospital</th>
<th>PEDIATRIC CLINIC EXPANSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>137805107.3.4 IT-1.20</td>
<td>Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Standalone)Third next available appointment (Non-standalone measure)</td>
<td>137805107</td>
</tr>
<tr>
<td>137805107.3.3 IT-1.1</td>
<td>Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381273 (Standalone measure)</td>
<td></td>
</tr>
<tr>
<td>137805107.3.5 IT-9.3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 [P-X1]:</strong> Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign</td>
<td><strong>Milestone 3 [P-1]:</strong> Establish an additional primary care clinic</td>
<td><strong>Milestone 6 [P-4]:</strong> Expand the hours of a primary care clinic, including evening and/or weekend hours</td>
<td><strong>Milestone 8 [I-12]:</strong> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
</tr>
<tr>
<td><strong>Metric 1 [P-X1.1]:</strong> Documentation of plan for the new clinic. Goal: Implementation plan (eligibility criteria, implementation components, responsibilities, and timeline). Data Source: UT Physicians' documents.</td>
<td><strong>Metric 1 [P-1.1]:</strong> Number of additional clinics. Goal: 1 new clinic Data Source: New primary care schedule and other UT Physicians' documents.</td>
<td><strong>Metric 1 [P-4.1]:</strong> Increased number of hours at primary care clinic over baseline Goal: 6 evening hours, 4 weekend hours Data Source: Clinic documentation</td>
<td><strong>Metric 1 [I-12.1]:</strong> Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase of 769 over previous reporting period for a total of 14,256 for the reporting period Data Source: Registry, EHR, claims or other UT Physicians' source</td>
</tr>
<tr>
<td><strong>Milestone 1 Estimated incentive payment:</strong> $ 2,200,710</td>
<td><strong>Milestone 3 Estimated incentive payment:</strong> $ 1,600,082</td>
<td><strong>Milestone 6 Estimated incentive payment:</strong> $ 2,400,111</td>
<td><strong>Milestone 8 Estimated incentive payment:</strong> $1,961,914</td>
</tr>
<tr>
<td><strong>Milestone 2 [P-X2]:</strong> Designate/hire personnel or teams to support and/or manage the project/intervention</td>
<td><strong>Milestone 4 [P-5]:</strong> Hire additional primary care providers and staff</td>
<td><strong>Milestone 7 [I-12]:</strong> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td><strong>Milestone 9 [I-11]:</strong> Patient satisfaction with primary care services.</td>
</tr>
<tr>
<td><strong>Metric 1 [P-X2.1]:</strong> Project managers, personnel assigned to teams, and team</td>
<td><strong>Metric 1 [P-5.1]:</strong> Documentation of increased number of providers and staff. Goal: 2 FTE Pediatricians, 3 FTE Nurse Practitioners, 6 Support staff Data Source: UT Physicians' report, policy, contract or other documentation</td>
<td><strong>Metric 1 [I-12.1]:</strong> Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase of 5,231 over previous reporting period for a total of 13,487</td>
<td><strong>Metric 1 [I-11.1]:</strong> Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores. Demonstrate improvement over prior reporting period.</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>IT-1.20</td>
<td>Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Standalone) Third next available appointment (Non-standalone measure) Pediatric/Young Adult Asthma Emergency Department Visits - NQF 1381273 (Standalone measure)</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>---------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td></td>
</tr>
<tr>
<td>responsibilities</td>
<td>for the reporting period</td>
<td>Goal: A statistically significant increase at the 95% level in both the overall mean score for patient satisfaction and in the score for ability to get appointment when wanted. Data Source: CG-CAHPS survey results (Press-Ganey)</td>
<td></td>
</tr>
<tr>
<td>Goal: 1 project manager, 3 support personnel</td>
<td>Data Source: Registry, EHR, claims or other UT Physicians’ source</td>
<td>Milestone 9 Estimated incentive payment: $1,961,914</td>
<td></td>
</tr>
<tr>
<td>Data Source: Program Documentation</td>
<td>Milestone 5 Estimated incentive payment: $2,400,110</td>
<td>Milestone 7 Estimated incentive payment: $1,600,081</td>
<td></td>
</tr>
<tr>
<td>Milestone 2 Estimated incentive payment: $2,200,710</td>
<td><strong>Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline: 0 (New Clinic) Goal: 8,256 Data Source: Registry, EHR, claims or other UT Physicians’ source</strong></td>
<td><strong>Milestone 5 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Milestone Bundle Amount: $4,401,420</strong></td>
<td><strong>Year 3 Estimated Milestone Bundle Amount: $4,800,245</strong></td>
<td><strong>Year 4 Estimated Milestone Bundle Amount: $4,800,221</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $17,925,714</strong></td>
<td></td>
<td><strong>Year 5 Estimated Milestone Bundle Amount: $3,923,828</strong></td>
<td></td>
</tr>
</tbody>
</table>
Project Summary:

Provider: Memorial Hermann Hospital (Memorial) is an 860 bed hospital located in Houston, TX and is part of the Houston-Sugarland-Baytown MSA. The MSA population served by Memorial is approximately 6,000,000 people.

Intervention(s): Memorial will establish the Houston Ship Channel South Pediatric Clinic which will provide primary care for pediatric patients in that area of Harris County. Memorial will contract UTHSC-H to provide physician services to complement Memorial’s investment in new technology, equipment and space to better provide pediatric services.

Need for the project: Prospective pediatric patients in the targeted service area described below currently face many roadblocks to adequate primary care including economic burdens, language barriers and lack of knowledge for seeking pediatric care. Due to the shortage of primary care providers in the community, the average wait period for a primary care appointment is 17 days, which results in increased reliance on hospital EDs for primary care and non-emergent care. The project will increase the percentage of patients who receive appropriate primary care including preventative services and regular monitoring for patients with chronic illnesses.

Target population: The target population is uninsured and underinsured children in the South area of the Houston Ship Channel that is between the Houston Ship Channel to the North, 610S to the West, Beltway 8S to the South and Beltway 8E to the East. This area encompasses 10 census tracts with a total of over 10,000 children living below the federal poverty level, who are on Medicaid, or would be eligible for Medicaid. It is estimated that 46.6% of the patients in the service area for this clinic are either uninsured or underinsured children and rely on Memorial Hermann’s and other hospitals’ emergency departments for primary care services.

Category 1 or 2 expected patient benefits: The clinic will provide a more appropriate setting for pediatric primary care for the target population. They will benefit primarily from better access to primary care and better management of illness and chronic conditions. The clinic is expected to be running at capacity (a conservatively estimated rate of approximately 15,000 patient visits per year) by July of DY4 and we expect to have provided a total of approximately 36,000 patient visits DY3-DY5. It is expected that 60% of these will be Medicaid/Medicaid-eligible patients (21,600).
Category 3 outcomes: IT-1.20 Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Standalone)—Increase the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months as measured by the Asthma Therapy Assessment Questionnaire (ATAQ).
Project Option 1.1.1- Establish More Primary Care Clinics: Pediatric Clinic Expansion – Houston Ship Channel South Pediatric Clinic

**Unique RHP Project Identification Number:** 137805107.1.4

**Performing Provider Name/TPI:** Memorial Hermann Hospital (Memorial)/137805107

**Project Description: 1.1/1.1.1:** Using the strengths developed during their longstanding partnership, Memorial and The University of Texas Health Science Center at Houston (UTHSC-H) intend to work together to address the shortage of pediatric primary and specialty care in Region 3. In this project, Memorial will establish the Houston Ship Channel South Pediatric Clinic, which will provide primary care for pediatric patients in an area of Harris County that is between the Houston Ship Channel to the north, 610S to the west, Beltway 8S to the south, and Beltway 8E to the east. Memorial has defined the service area for this clinic as a priority area for pediatric services, because it contains 10 of the 81 census tracts that make up the top 10% of all census tracts in Harris County with the greatest number of people below the age of 18 living below the federal poverty level (FPL). (The census tracts included are 3333, 3328, 3235, 3234, 3230, 3220, 3213, 3209, 3208, and 3202.) The number of children living below the FPL in these 10 census tract areas is estimated to be approximately 10,113, who would either be on Medicaid, or are Medicaid-eligible. This clinic will market services to this population and provide services to those who respond. The capacity of the clinic is expected to be over 15,000 patient visits per year. Using a very conservative estimate of 50% of these clinic visits being with Medicaid/Medicaid-eligible patients, we would see a total of at least 7,500 Medicaid primary care visits per year. (UT Physicians’ current payer mix for pediatrics includes a 60% mix of Medicaid and non-resource.) We estimate that we will have provided 36,000 patient visits by the end of DY5, with approximately 21,600 of them being for patients on Medicaid, or who are Medicaid-eligible (using UT Physicians’ current rate of Medicaid/Medicaid-eligible pediatric patients). Furthermore, these areas have particularly high numbers of Hispanics (69%), for whom language, as well as poverty, may pose a barrier to obtaining primary care for their children. The service area for this clinic includes a large population, for whom there exists economic, cultural, language, and transportation barriers to receiving primary care. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties.) In order to address the unique needs of different communities in the greater Houston area, Memorial has chosen to establish a pediatric clinic in this area as an independent DSRIP project.

Using their longstanding partnership to provide quality healthcare as a base, Memorial will contract UTHSC-H to provide physician services to complement Memorial’s investment in new technology, equipment and space to better provide pediatric services. Specifically, UTHSC-H will redirect pediatricians already on its staff who have the capacity to care for additional patients, recruit additional pediatricians, or increase residency programs to fill the need for
additional pediatric specialists. UTHSC-H is uniquely positioned to attract and retain new physicians due to its accomplishments as a world-class academic and research institution. This additional service line will avoid duplication and draw on the strength of UTHSC-H’s academic presence in the field of pediatric medicine, and will also benefit Memorial by increasing the quantity, quality, and scope of services provided at its facilities.

Practically, Memorial will subcontract with UTHSC-H to provide physician and other services needed to implement this project. For example, Memorial will lease additional space to open the North Harris County clinic. This space will include additional consulting, exam and procedure rooms. Memorial will also subcontract with UTHSC-H to provide primary care providers and support staff to operationalize the project. For all services in which UTHSC-H is a subcontractor, Memorial will pay an agreed rate that is set in advance and represents fair market value for services negotiated in the ordinary course of business through an arms-length transaction.

**Goal(s) and relationship to Regional goal(s):**

**Project goals:**

Expand the capacity of pediatric primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that pediatric patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.

This project meets the following Region 3 goals:

One of the goals of the region is to “Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay”. Expansion of primary care capacity certainly relates to this goal as it will make it easier for Memorial to provide care to underserved populations.

**Challenges and how addressed:**

This project faces three key challenges. First, Memorial must raise awareness and change existing patterns for seeking health care services for some patients. A second challenge is to raise awareness for the service delivery model offered by these new sites so that patients who currently don’t have access to after-hours care learn that this type of care is available through a physician’s clinic rather than turning to emergent or urgent care clinics. And finally, recruiting additional primary care providers and pediatric specialists in this competitive environment will be a challenge. Memorial will address these challenges by implementing other projects to reduce inappropriate ED use, educating patients on the benefits of primary care, and aggressively recruiting primary care providers by offering competitive salaries and other incentives to practice in the outlying clinics.
5-year expected outcome for provider and patients:

There will be shortening of waiting times for primary pediatric care appointments and increased uptake of primary pediatric care services in this specific service area, which will increase the percentage of patients who receive appropriate primary health care, including preventative services and regular monitoring for those patients with chronic illnesses. In total, we expect to provide primary care visits totaling over 15,000 per year, once the clinic is running at capacity. Since this clinic will serve an area with a high rate of children living below poverty, we expect that at least 7,500 of these patient visits per year will be from the Medicaid/Medicaid-eligible population. We expect to have provided a total of approximately 36,000 patient visits DY3-DY5, with approximately 21,600 of them being Medicaid/Medicaid-eligible patients.

Starting Point/Baseline: Memorial has identified the targeted service area needing increased access to pediatric primary care. Since this will be a new clinic, the baseline will have to be established during DY3.

Rationale:

Reasons for selecting the project option: In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively (comparable ratios for US total are 219.5 and 90.5, respectively). From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Therefore, there is a significant need to expand primary care in order to facilitate delivery system reform.

Research has shown that access to primary care is associated with better health outcomes at less cost. Access to primary care ensures better preventive care and better management of chronic disease, with lack of access often resulting in more expensive care, received in hospitals and emergency departments (ED). For the fiscal year 2010, 10% of all potentially preventable hospitalizations (PPR) were ambulatory care sensitive. In 2009, 41% (390,945) of ED visits in Houston were primary care related (PCR), including non-urgent, primary care treatable, and primary care preventable, and for 26.8% (104,762) of these PCR visits, Medicaid was the payor. Getting more patients into primary care will help to reduce the use of this more costly care. Placing more primary care providers out in the communities will help to address transportation access barriers and the expansion of clinic service hours will provide a greater selection of available appointment times. By increasing primary care capacity, engaging more people in the primary care system, and avoiding inappropriate utilization of costly services, the community will experience better health outcomes and greater patient satisfaction.⁹

⁹ PPR rate was from the Texas Health and Human Services Commission report on Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal year 2010, published January, 2012. The statistics for ED use were from the Houston Hospitals Emergency Department Use Study (January 1, 2009 through
In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Because UTHSC-H will IGT on behalf of Memorial for its successful implementation of delivery system improvements under the Waiver, this structure results in a payment from a private hospital to an entity that provides its IGT, which arguably raises questions regarding provider donations. Nonetheless, this collaboration is the most to effective and efficient structure to expand access to pediatric services to the community, and ensure overall improvement to the Region 3 delivery system. This collaboration is a natural progression of the existing relationship and the clinical strengths of Memorial and UTHSC-H. Memorial is the largest not-for-profit healthcare system in Texas and serves the greater Houston community through 12 hospitals, a vast network of affiliated physicians and numerous specialty programs and services. With over 4,000 medical staff members, 26 residency programs, 48 fellowship programs, and over 1,300 physicians in training, Memorial is dedicated to providing high quality health services in order to improve the health of the people in Southeast Texas. The mission of UTHSC-H is to educate health science professionals, discover and translate advances in the biomedical and social sciences, and model the best practices in clinical care and public health. UTHSC-H strives to improve the health of the public in the State of Texas through educating future public health practitioners and bringing evidence based public health practices to Texas. UTHSC-H’s faculty of over 900 physicians in 80 specialties provide comprehensive care for patients while teaching 800 medical students and over 900 residents in over 60 accredited residency/fellowship programs.

**Core Components:**

Through the new Houston Ship Channel South Pediatric Clinic, we propose to:

a) Memorial will identify and lease appropriate space within the defined service area to establish the new clinic that includes reception, consulting, exam and procedure rooms, and will provide the necessary equipment and furnishings.

December 31, 2009), Final Report included in the 2010 Harris County Community Needs Assessment for Memorial Hermann.
b) UT Physicians will be contracted at fair market value to provide primary care physicians, advanced practice providers, and support staff to operate the clinic.

c) In addition to regular business hours, the clinic will operate with expanded evening and Saturday hours to increase access for individuals that are not able to leave their jobs for healthcare appointments, and to provide care for those needing urgent care services that can be accommodated in a primary care clinic.

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

CN1 – Primary Care

CN8 – High rates of inappropriate emergency department utilization

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

This project represents a significant improvement in Memorial’s ability to deliver primary healthcare to babies, children, and adolescents. This new initiative proposes to add space, providers, support staff, and extended service hours in a location where economic and cultural barriers to receiving appropriate healthcare are indicative of a need for services that are conveniently located and available when needed. This project is an expansion of services in order to improve access to care.

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

OD-1 Primary Care and Chronic Disease Management: IT-1.20 Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Non-Standalone)

Increase the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months as measured by the Asthma Therapy Assessment Questionnaire (ATAQ). The ATAQ was found to have “good internal consistency and strong relationships with existing validated measures of childhood health status, asthma impact, and health care utilization.” The score range on the 7-item ATAQ is 0-7, with 0 showing complete control and each score of 1 thereafter indicating an area in need of improved management. The ATAQ will be administered at each patient visit for patients with a diagnosis of asthma. Improvement is defined as a downward trend in the total score for the 7-items on the ATAQ for each individual patient.

13 Ibid.
OD-1 Primary Care and Chronic Disease Management: IT-1.1 Third next available appointment (Non-standalone measure)

Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

OD-9 Right Care, Right Setting: IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381273 (Standalone measure)

Numerator: Percentage of clinic patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period. Denominator: Denominator is all clinic patients age two through age 18, diagnosed with asthma during the measurement period. The denominator will include recipients with claims with asthma as primary or secondary diagnoses with the dates of service being within the measurement period.

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

Asthma is one of the most common chronic illnesses among children in the U.S. The National Health Interview Survey (2011) found that 14% of all children living in the U.S., 21% of non-Hispanic black children, and 18% of children in poor families had ever been diagnosed with asthma. The number of children residing in the defined service area for this clinic is estimated at over 22,750, with 8% of those being non-Hispanic black (over 1,900), 69.1% being Hispanic (over 15,700) and 44.5% living below the federal poverty level (over 10,000). (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties.) By extrapolating the U.S. statistics on children with asthma to the service area for this clinic, we can conservatively estimate that there are at least 3,185 children in this area suffering from asthma. Since the service area for this clinic has a high proportion of children living below the federal poverty level and a high proportion of non-Hispanic black children, achieving better asthma control for these patients will be an important and worthy outcome measure of increasing access to primary care services for children.

After the assessment of severity for the initial diagnosis, the goal then becomes asthma control, demonstrated through symptom manifestation and disease activity. The use of the ATAQ itself has benefits beyond simple measurement—it is a tool to ensure regular assessment and the


consistent questioning can teach children and/or their parents which symptoms and experiences should be anticipated for managing their asthma.16

By increasing access to primary care and providing education and support in gaining control over asthma, the project has the potential to prevent the acute worsening of the illnesses, thereby decreasing the need for emergency care. Hence ED visits for asthma will be a good outcome measure for this project. Finally, patients are more likely to arrive for their appointments when they are able to get them when needed and when most convenient. Consequently, we will be measuring third next available appointment as a measure of increased access to primary care services.

**Relationship to Other Projects:** This project is part of Memorial’s larger plans to expand and develop primary care and specialty care services, while improving access to care. Expanding primary care supports/reinforces several of the Category 1 and 2 projects: increasing the number of physicians rotating through the primary care residency program will have a direct impact on Expanding Primary Care Capacity (1.2); this project not only will increase the number of available physicians to participate in medical homes (2.1), it will also ensure that they are trained in the medical home concept; this project reinforces the Redesign of Primary Care (2.3), the Redesign to Improve the Patient Experience (2.4).

**Relationship to Other Performing Providers’ Projects in the RHP:** Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

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

**Project Valuation:** The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the

---

magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

The expansion of primary care clinics will help address a substantial need in the community for increased access to primary care. It will also go a long way towards achieving the Waiver goal of improving outcomes while curbing the risk of healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes.
<table>
<thead>
<tr>
<th><strong>137805107.1.4</strong></th>
<th><strong>OPTION 1.1.1</strong></th>
<th><strong>PEDIATRIC CLINIC EXPANSION</strong></th>
<th><strong>137805107</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 3</td>
<td>137805107.3.7</td>
<td>Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Standalone)</td>
<td>Third next available appointment (Non-standalone measure)</td>
</tr>
<tr>
<td>Outcome Measure(s):</td>
<td>137805107.3.6</td>
<td></td>
<td>Pediatric/Young Adult Asthma Emergency Department Visits - NQF 1381273 (Standalone measure)</td>
</tr>
<tr>
<td></td>
<td>137805107.3.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Memorial Hermann Hospital</td>
<td>IT-1.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IT-1.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IT-9.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Milestone 1</strong> [P-X1]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign</td>
<td><strong>Milestone 3</strong> [P-1]: Establish an additional primary care clinic</td>
<td><strong>Milestone 6</strong> [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours</td>
<td><strong>Milestone 8</strong> [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
</tr>
<tr>
<td>Metric 1 [P-X1.1]: Documentation of plan for the new clinic. Goal: Implementation plan (eligibility criteria, implementation components, responsibilities, and timeline). Data Source: UT Physicians' documents.</td>
<td>Metric 1 [P-1.1]: Number of additional clinics. Goal: 1 new clinic Data Source: New primary care schedule and other UT Physicians' documents.</td>
<td>Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline Goal: 6 evening hours, 4 weekend hours Data Source: Clinic documentation</td>
<td>Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase of 769 over previous reporting period for a total of 14,256 for the reporting period Data Source: Registry, EHR, claims or other UT Physicians' source</td>
</tr>
<tr>
<td>Milestone 1 Estimated incentive payment: $ 2,114,778</td>
<td>Milestone 3 Estimated incentive payment: $ 1,538,073</td>
<td>Milestone 6 Estimated incentive payment: $ 2,313,816</td>
<td>Milestone 8 Estimated incentive payment: $1,911,413</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-X2]: Designate/hire personnel or teams to support and/or manage the project/intervention</td>
<td><strong>Milestone 4</strong> [P-5]: Hire additional primary care providers and staff</td>
<td><strong>Milestone 7</strong> [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td><strong>Milestone 9</strong> [I-11]: Patient satisfaction with primary care services.</td>
</tr>
<tr>
<td>Metric 1 [P-X2.1]: Project managers, personnel assigned to teams, and team</td>
<td>Metric 1 [P-5.1]: Documentation of increased number of providers and staff. Goal: 2 FTE Pediatricians, 3 FTE Nurse Practitioners, 6 Support staff Data Source: UT Physicians' report, policy, contract or other documentation</td>
<td>Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase of 5,231 over previous reporting period for a total of 13,487</td>
<td>Metric 1 [I-11.1]: Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores. Demonstrate improvement over prior reporting period.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**OPTION 1.1.1**

**PEDIATRIC CLINIC EXPANSION**

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s)</th>
<th>137805107.3.7</th>
<th>137805107.3.6</th>
<th>137805107.3.8</th>
<th>137805107.3.9</th>
<th>137805107.3.10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memoria</td>
<td>Hermann Hospital</td>
<td>IT-1.20</td>
<td>IT-1.1</td>
<td>IT-9.3</td>
<td>Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Standalone)</td>
<td>Third next available appointment (Non-standalone measure)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Year 2: 137805107.1.4**

- **responsibilities**
  - Goal: 1 project manager, 3 support personnel
  - Data Source: Program Documentation

- **Milestone 2 Estimated incentive payment:** $2,114,778

**Year 3: 137805107.3.7**

- **Milestone 4 Estimated incentive payment:** $1,538,073

**Milestone 5 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.**

**Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.**

- **Baseline:** 0 (New Clinic)
- **Goal:** 8,256
- **Data Source:** Registry, EHR, claims or other UT Physicians' source

- **Milestone 5 Estimated incentive payment:** $1,538,072

**Year 4: 137805107.3.6**

- **Milestone 7 Estimated incentive payment:** $2,313,816

**Year 5: 137805107.3.8**

- **Milestone 9 Estimated incentive payment:** $1,911,413

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $17,294,232
**Project Option: 1.1.1 - 1.1 Expand Primary Care Capacity: Pediatric Clinic Expansion – Houston Ship Channel North Pediatric Clinic**

**Unique Project ID:** 137805107.1.5  
**Performing Provider Name/TPI:** Memorial Hermann Hospital / 137805107

**Project Summary:**

**Provider:** Memorial Hermann Hospital System (Memorial Hermann) is a 1,164 bed hospital system consisting of 4 campuses in the Houston-Sugarland-Baytown MSA. The system serves a population of approximately 6,000,000 people.

**Intervention(s):** Memorial will establish the Houston Ship Channel North Pediatric Clinic which will provide primary care for pediatric patients in that area of Harris County. Memorial will contract UTHSC-H to provide physician services to complement Memorial’s investment in new technology, equipment and space to better provide pediatric services.

**Need for the project:** Prospective pediatric patients in the targeted service area currently face many roadblocks to adequate primary care including economic burdens, language barriers and lack of knowledge for seeking pediatric care. Due to the shortage of primary care providers in the community, the average wait period for a primary care appointment is 17 days, which results in increased reliance on hospital EDs for primary care and non-emergent care. The project will increase the percentage of patients who receive appropriate primary care including preventative services and regular monitoring for patients with chronic illnesses.

**Target population:** The target population is uninsured and underinsured children in North the area of the Houston Ship Channel that is between Beltway 8 to the North, 610E to the West, the Houston Ship Channel to the South, and Baytown to the East. This area encompasses 10 census tracts with a total of over 10,000 children living below the federal poverty level, who are on Medicaid, or would be eligible for Medicaid. It is estimated that 41.4% of the patients in the service area for this clinic are either uninsured or underinsured children and rely on Memorial Hermann’s and other hospitals’ emergency departments for primary care services.

**Category 1 or 2 expected patient benefits:** The clinic will provide a more appropriate setting for pediatric primary care for the target population. They will benefit primarily from better access to primary care and better management of illness and chronic conditions. The clinic is expected to be running at capacity (a conservatively estimated rate of approximately 15,000 patient visits per year) by July of DY4 and we expect to have provided a total of approximately 36,000 patient visits DY3-DY5. It is expected that 60% of these will be Medicaid/Medicaid-eligible patients (21,600).

**Category 3 outcomes:**  
IT-1.20 Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Standalone)—Increase the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months as measured by the Asthma Therapy Assessment Questionnaire (ATAQ).
Project Option 1.1.1 Establish More Primary Care Clinics: Pediatric Clinic Expansion – Houston Ship Channel North Pediatric Clinic

Unique RHP Project Identification Number: 137805107.1.5

Performing Provider Name/TPI: Memorial Hermann Hospital (Memorial)/137805107

Project Description: 1.1/1.1.1: Using the strengths developed during their longstanding partnership, Memorial and The University of Texas Health Science Center at Houston (UTHSC-H) intend to work together to address the shortage of pediatric primary and specialty care in Region 3. In this project, Memorial will establish the Houston Ship Channel North Pediatric Clinic, which will provide primary care for pediatric patients in an area of Harris County that is between Beltway 8 to the north, 610E to the west, the Houston Ship Channel to the south, and Baytown to the east. Memorial has defined the service area for this clinic as a priority area for pediatric services, because it contains 8 of the 81 census tracts that make up the top 10% of all census tracts in Harris County with the greatest number of people below the age of 18 that are living below the federal poverty level (FPL). (The census tracts included are 2535, 2526, 2523.01, 2335, 2331.02, 2327.01, 2324.03, and 2323.01.) The number of children living below the FPL in these 8 census tract areas is estimated to be approximately 8,054, who would either be on Medicaid, or are Medicaid-eligible. This clinic will market services to this population and provide services to those who respond. The capacity of the clinic is expected to be over 15,000 patient visits per year. Using a very conservative estimate of 50% of these clinic visits being with Medicaid/Medicaid-eligible patients, we would see a total of at least 7,500 Medicaid primary care visits per year. (UT Physicians’ current payer mix for pediatrics includes a 60% mix of Medicaid and non-resource.) We estimate that we will have provided 36,000 patient visits by the end of DY5, with approximately 21,600 of them being for patients on Medicaid, or who are Medicaid-eligible (using UT Physicians’ current rate of Medicaid/Medicaid-eligible pediatric patients). Furthermore, these areas have particularly high numbers of Hispanics (64%), for whom language, as well as poverty, may pose a barrier to obtaining primary care for their children. Black/African Americans, another segment of the population that tend to be medically underserved, also make up a significant proportion of the population in these census tracts (18.5%). The service area for this clinic includes large populations with economic, cultural, language, and transportation barriers to receiving primary care. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties.) In order to address the unique needs of different communities in the greater Houston area, Memorial has chosen to establish a pediatric clinic in this area as an independent DSRIP project.

Using their longstanding partnership to provide quality healthcare as a base, Memorial will contract UTHSC-H to provide physician services to complement Memorial’s investment in new technology, equipment and space to better provide pediatric services. Specifically, UTHSC-H
will redirect pediatricians already on its staff who have the capacity to care for additional patients, recruit additional pediatricians, or increase residency programs to fill the need for additional pediatric specialists. UTHSC-H is uniquely positioned to attract and retain new physicians due to its accomplishments as a world-class academic and research institution. This additional service line will avoid duplication and draw on the strength of UTHSC-H’s academic presence in the field of pediatric medicine, and will also benefit Memorial by increasing the quantity, quality, and scope of services provided at its facilities.

Practically, Memorial will subcontract with UTHSC-H to provide physician and other services needed to implement this project. For example, Memorial will lease additional space to open the North Harris County clinic. This space will include additional consulting, exam and procedure rooms. Memorial will also subcontract with UTHSC-H to provide primary care providers and support staff to operationalize the project. For all services in which UTHSC-H is a subcontractor, Memorial will pay an agreed rate that is set in advance and represents fair market value for services negotiated in the ordinary course of business through an arms-length transaction.

**Goal(s) and relationship to Regional goal(s):**

**Project goals:**

Expand the capacity of pediatric primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that pediatric patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.

This project meets the following Region 3 goals:

One of the goals of the region is to “Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay”. Expansion of primary care capacity certainly relates to this goal as it will make it easier for Memorial to provide care to underserved populations.

**Challenges and how addressed:**

This project faces three key challenges. First, Memorial must raise awareness and change existing patterns for seeking health care services for some patients. A second challenge is to raise awareness for the service delivery model offered by these new sites so that patients who currently don’t have access to after-hours care learn that this type of care is available through a physician’s clinic rather than turning to emergent or urgent care clinics. And finally, recruiting additional primary care providers and pediatric specialists in this competitive environment will be a challenge. Memorial will address these challenges by implementing other projects to reduce inappropriate ED use, educating patients on the benefits of primary care, and aggressively
recruiting primary care providers by offering competitive salaries and other incentives to practice in the outlying clinics.

**5-year expected outcome for provider and patients:**

There will be shortening of waiting times for primary pediatric care appointments and increased uptake of primary pediatric care services in this specific service area, which will increase the percentage of patients who receive appropriate primary health care, including preventative services and regular monitoring for those patients with chronic illnesses. In total, we expect to provide primary care visits totaling over 15,000 per year, once the clinic is running at capacity. Since this clinic will serve an area with a high rate of children living below poverty, we expect that at least 7,500 of these patient visits per year will be from the Medicaid/Medicaid-eligible population. We expect to have provided a total of approximately 36,000 patient visits DY3-DY5, with approximately 21,600 of them being Medicaid/Medicaid-eligible patients.

**Starting Point/Baseline:** Memorial has identified the targeted service area needing increased access to pediatric primary care. Since this will be a new clinic, the baseline will have to be established during DY3.

**Rationale:**

In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively (comparable ratios for US total are 219.5 and 90.5, respectively). From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Therefore, there is a significant need to expand primary care in order to facilitate delivery system reform.

Research has shown that access to primary care is associated with better health outcomes at less cost. Access to primary care ensures better preventive care and better management of chronic disease, with lack of access often resulting in more expensive care, received in hospitals and emergency departments (ED). For the fiscal year 2010, 10% of all potentially preventable hospitalizations (PPR) were ambulatory care sensitive. In 2009, 41% (390,945) of ED visits in Houston were primary care related (PCR), including non-urgent, primary care treatable, and primary care preventable, and for 26.8% (104,762) of these PCR visits, Medicaid was the payor. Getting more patients into primary care will help to reduce the use of this more costly care. Placing more primary care providers out in the communities will help to address transportation access barriers and the expansion of clinic service hours will provide a greater selection of available appointment times. By increasing primary care capacity, engaging more people in the primary care system, and avoiding inappropriate utilization of costly services, the community will experience better health outcomes and greater patient satisfaction.17

---

In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Because UTHSC-H will IGT on behalf of Memorial for its successful implementation of delivery system improvements under the Waiver, this structure results in a payment from a private hospital to an entity that provides its IGT, which arguably raises questions regarding provider donations. Nonetheless, this collaboration is the most to effective and efficient structure to expand access to pediatric services to the community, and ensure overall improvement to the Region 3 delivery system. This collaboration is a natural progression of the existing relationship and the clinical strengths of Memorial and UTHSC-H. Memorial is the largest not-for-profit healthcare system in Texas and serves the greater Houston community through 12 hospitals, a vast network of affiliated physicians and numerous specialty programs and services. With over 4,000 medical staff members, 26 residency programs, 48 fellowship programs, and over 1,300 physicians in training, Memorial is dedicated to providing high quality health services in order to improve the health of the people in Southeast Texas. The mission of UTHSC-H is to educate health science professionals, discover and translate advances in the biomedical and social sciences, and model the best practices in clinical care and public health. UTHSC-H strives to improve the health of the public in the State of Texas through educating future public health practitioners and bringing evidence based public health practices to Texas. UTHSC-H’s faculty of over 900 physicians in 80 specialties provide comprehensive care for patients while teaching 800 medical students and over 900 residents in over 60 accredited residency/fellowship programs.

**Core Components:**

Through the new Houston Ship Channel North Pediatric Clinic, we propose to:

a) Memorial will identify and lease appropriate space within the defined service area to establish the new clinic that includes reception, consulting, exam and procedure rooms, and will provide the necessary equipment and furnishings.

ED use were from the Houston Hospitals Emergency Department Use Study (January 1, 2009 through December 31, 2009), Final Report included in the 2010 Harris County Community Needs Assessment for Memorial Hermann.
b) UT Physicians will be contracted at fair market value to provide primary care physicians, advanced practice providers, and support staff to operate the clinic.

c) In addition to regular business hours, the clinic will operate with expanded evening and Saturday hours to increase access for individuals that are not able to leave their jobs for healthcare appointments, and to provide care for those needing urgent care services that can be accommodated in a primary care clinic.

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

CN1 – Primary Care

CN8 – High rates of inappropriate emergency department utilization

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

This project represents a significant improvement in Memorial’s ability to deliver primary healthcare to babies, children, and adolescents. This new initiative proposes to add space, providers, support staff, and extended service hours in a location where economic and cultural barriers to receiving appropriate healthcare are indicative of a need for services that are conveniently located and available when needed. This project is an expansion of services in order to improve access to care.

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

OD-1 Primary Care and Chronic Disease Management: IT-1.20 Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Non-Standalone)

Increase the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months as measured by the Asthma Therapy Assessment Questionnaire (ATAQ).\(^{18,19,20}\) The ATAQ was found to have “good internal consistency and strong relationships with existing validated measures of childhood health status, asthma impact, and health care utilization.”\(^{21}\) The score range on the 7-item ATAQ is 0-7, with 0 showing complete control and each score of 1 thereafter indicating an area in need of improved management. The ATAQ will be administered at each patient visit for patients with a diagnosis of asthma. Improvement is defined as a downward trend in the total score for the 7-items on the ATAQ for each individual patient.

---


\(^{21}\) Ibid.
OD-1 Primary Care and Chronic Disease Management: IT-1.1 Third next available appointment (Non-standalone measure)

Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

OD-9 Right Care, Right Setting: IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381273 (Standalone measure)

Numerator: Percentage of clinic patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period. Denominator: Denominator is all clinic patients age two through age 18, diagnosed with asthma during the measurement period. The denominator will include recipients with claims with asthma as primary or secondary diagnoses with the dates of service being within the measurement period.

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

Asthma is one of the most common chronic illnesses among children in the U.S.\(^\text{22}\) The National Health Interview Survey (2011) found that 14% of all children living in the U.S., 21% of non-Hispanic black children, and 18% of children in poor families had ever been diagnosed with asthma.\(^\text{23}\) The number of children residing in the defined service area for this clinic is estimated over 20,500, with 18.5% of those being non-Hispanic black (over 3,700) and 39% living below the federal poverty level (over 7,995). (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties.) By extrapolating the U.S. statistics on children with asthma to the service area for this clinic, we can conservatively estimate that there are at least 3,700 children in this area suffering from asthma. Since the service area for this clinic has a high proportion of children living below the federal poverty level and a high proportion of non-Hispanic black children, achieving better asthma control for these patients will be an important and worthy outcome measure of increasing access to primary care services for children.

After the assessment of severity for the initial diagnosis, the goal then becomes asthma control, demonstrated through symptom manifestation and disease activity. The use of the ATAQ itself has benefits beyond simple measurement—it is a tool to ensure regular assessment and the


consistent questioning can teach children and/or their parents which symptoms and experiences should be anticipated for managing their asthma.\textsuperscript{24}

By increasing access to primary care and providing education and support in gaining control over asthma, the project has the potential to prevent the acute worsening of the illnesses, thereby decreasing the need for emergency care. Hence ED visits for asthma will be a good outcome measure for this project. Finally, patients are more likely to arrive for their appointments when they are able to get them when needed and when most convenient. Consequently, we will be measuring third next available appointment as a measure of increased access to primary care services.

**Relationship to Other Projects:** This project is part of Memorial’s larger plans to expand and develop primary care and specialty care services, while improving access to care. Expanding primary care supports/reinforces several of the Category 1 and 2 projects: increasing the number of physicians rotating through the primary care residency program will have a direct impact on Expanding Primary Care Capacity (1.2); this project not only will increase the number of available physicians to participate in medical homes (2.1), it will also ensure that they are trained in the medical home concept; this project reinforces the Redesign of Primary Care (2.3), the Redesign to Improve the Patient Experience (2.4).

**Relationship to Other Performing Providers’ Projects in the RHP:** Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

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

**Project Valuation:** The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the

\textsuperscript{24} Barbara P. Yawn, Susan K. Brenneman, Felicia C. Allen-Ramey, Michael D. Cabana and Leona E. Markson. Assessment of Asthma Severity and Asthma Control in Children. Pediatrics 2006;118;322
magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

The expansion of primary care clinics will help address a substantial need in the community for increased access to primary care. It will also go a long way towards achieving the Waiver goal of improving outcomes while curbing the risk of healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s)</th>
<th>PEDIATRIC CLINIC EXPANSION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>137805107.1.5</td>
<td>Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Standalone)</td>
</tr>
<tr>
<td></td>
<td>137805107.3.10</td>
<td>Third next available appointment (Non-standalone measure)</td>
</tr>
<tr>
<td></td>
<td>137805107.3.9</td>
<td>Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381273</td>
</tr>
<tr>
<td></td>
<td>137805107.3.11</td>
<td>(Standalone measure)</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td>(10/1/2012 – 9/30/2013)</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 1</strong></td>
<td>P-X1: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign</td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>P-X1.1: Documentation of plan for the new clinic. Goal: Implementation plan (eligibility criteria, implementation components, responsibilities, and timeline). Data Source: UT Physicians' documents.</td>
<td></td>
</tr>
<tr>
<td>Milestone 1 Estimated incentive payment: $ 2,200,710</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 2</strong></td>
<td>P-X2: Designate/hire personnel or teams to support and/or manage the project/intervention</td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>P-X2.1: Project managers, personnel assigned to teams, and team</td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong></td>
<td>(10/1/2013 – 9/30/2014)</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3</strong></td>
<td>P-1: Establish an additional primary care clinic</td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>P-1.1: Number of additional clinics. Goal: 1 new clinic Data Source: New primary care schedule and other UT Physicians' documents.</td>
<td></td>
</tr>
<tr>
<td>Milestone 3 Estimated incentive payment: $ 1,600,082</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 4</strong></td>
<td>P-5: Hire additional primary care providers and staff</td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>P-5.1: Documentation of increased number of providers and staff. Goal: 2 FTE Pediatricians, 3 FTE Nurse Practitioners, 6 Support staff Data Source: UT Physicians' report, policy, contract or other documentation</td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong></td>
<td>(10/1/2014 – 9/30/2015)</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5</strong></td>
<td>P-4: Expand the hours of a primary care clinic, including evening and/or weekend hours</td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>P-4.1: Increased number of hours at primary care clinic over baseline Goal: 6 evening hours, 4 weekend hours Data Source: Clinic documentation</td>
<td></td>
</tr>
<tr>
<td>Milestone 5 Estimated incentive payment: $ 2,400,111</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 6</strong></td>
<td>P-5: Expand the hours of a primary care clinic, including evening and/or weekend hours</td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>P-5.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase of 5,231 over previous reporting period for a total of 13,487</td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong></td>
<td>(10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 7</strong></td>
<td>I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase of 769 over previous reporting period for a total of 14,256 for the reporting period Data Source: Registry, EHR, claims or other UT Physicians' source</td>
<td></td>
</tr>
<tr>
<td>Milestone 7 Estimated incentive payment: $ 1,961,914</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 8</strong></td>
<td>I-11: Patient satisfaction with primary care services.</td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>I-11.1: Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores. Demonstrate improvement over prior reporting period.</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 9</strong></td>
<td>I-12: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>I-12.1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase of 5,231 over previous reporting period for a total of 13,487</td>
<td></td>
</tr>
<tr>
<td>Milestone 8 Estimated incentive payment: $ 1,961,914</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan
Region 3
368
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>IT-1.20</th>
<th>IT-1.1</th>
<th>IT-9.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>137805107.3.10 Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Standalone)</td>
<td>Third next available appointment (Non-standalone measure)</td>
<td>Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381273 (Standalone measure)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 4 Estimated incentive payment: $ 1,600,082</td>
<td>for the reporting period Data Source: Registry, EHR, claims or other UT Physicians' source</td>
<td>Milestone 7 Estimated incentive payment: $ 2,400,110</td>
<td>Goal: A statistically significant increase at the 95% level in both the overall mean score for patient satisfaction and in the score for ability to get appointment when wanted. Data Source: CG-CAHPS survey results (Press-Ganey) Milestone 9 Estimated incentive payment: $1,961,914</td>
</tr>
<tr>
<td>Goal: 1 project manager, 3 support personnel Data Source: Program Documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 2 Estimated incentive payment: $ 2,200,710</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Milestone 5 Estimated incentive payment: $ 1,600,081</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline: 0 (New Clinic) Goal: 8,256 Data Source: Registry, EHR, claims or other UT Physicians' source</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Milestone 5 Estimated incentive payment: $ 1,600,081</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Year 5 Estimated incentive payment: $ 2,400,110</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Year 5 Estimated incentive payment: $ 1,961,914</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 17,294,232**
Memorial Hermann Northwest Hospital
Pass 1
**Project Option:** 1.1.1 Establish more primary care clinics: Primary Care Expansion School Based Health

**Performing Provider:** Memorial Hermann Hospital System/TPI 020834001

**Unique Project ID:** 020834001.1.1

- **Provider:** Memorial Hermann Hospital System (Memorial Hermann) is a 1,164 bed hospital system consisting of 4 campuses in the Houston-Sugarland-Baytown MSA. The system serves a population of approximately 6,000,000 people.

- **Intervention(s):** Memorial Hermann intends to increase the number of school-based primary care sites in low income communities for people with limited access to health and dental care in the community. The project will expand the Memorial Hermann Health Centers for Schools program by 3 health centers and 1 mobile dental van.

- **Need for the project:** Many low-income children and teens receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. By enhancing access points by providing care where children and teens are located – at school – students and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

- **Target population:** The target population is children and teens who are uninsured or underinsured and attend school. Currently, Memorial Hermann has school-based clinics in 3 school districts. Memorial Hermann believes there is a need for three additional clinics, in services areas where 35% of the patients are either uninsured or underinsured teens or children. One of these clinics may be added to a school district that already has an existing clinic; however, the new clinic will serve a distinct student population. These new school clinics will serve children who do not otherwise get healthcare.

- **Category 1 or 2 expected patient benefits:** The 3 new health centers and 1 mobile dental van will result in serving approximately 18 additional schools, opening access to approximately 15,000 additional students and providing approximately 9,500 visits.

  DY3: 2500 medical/social work/navigation/dietitian/ and dental visits in all locations combined
  DY4: 7000 medical/social work/navigation/dietitian/ and dental visits in all locations combined
  DY5: 9500 medical/social work/navigation/dietitian/ and dental visits in all locations combined

  Memorial Hermann estimates that approximately 80% of the patients served by this project will be Medicaid or indigent. Included in the 80% are under-insured students, unable to pay high deductibles and co-payments.

- **Category 3 outcomes:** IT 7.2 – A baseline will be established in DY3 of children with untreated dental issues. In DY 4, Memorial Hermann intends to improve the untreated dental caries measurement by at least 15% over the baseline recorded in DY 3 for that
measurement. In DY 5, Memorial Hermann intends to improve the same measurement by at least 25% over baseline. The project will also include IT-1.1 third next available appointment as an additional Category 3 outcome measure because Memorial Hermann believes that this project will result in increased access and decreased wait times to see primary care providers.
Project Option - 1.1.1 Establish more primary care clinics: Primary Care Expansion
School Based Health

Unique RHP Project Identification Number: 020834001.1.1

Performing Provider Name/TPI: Memorial Hermann Hospital System/TPI 020834001

Project Description: Increase the number of school based primary care sites in low income communities for people with limited access in the community. Memorial Hermann initially proposes to offer this service to patients in the following zip codes: 77506, 77099, and 77032.

Memorial Hermann wishes to expand the Memorial Hermann Health Centers for Schools Program, which is designed as a medical home for uninsured children and a secondary access point for insured children. Memorial Hermann Health Centers for Schools exists for many reasons, but its primary purpose is to combat barriers to primary care for school aged children. Schools to be served by this award-winning program have always been selected by identifying students with the highest prevalence of unmet medical and psychosocial needs. Primary medical, dental and mental health care is provided.

The Memorial Hermann Health Centers for Schools are located in schools and school districts that have students with documented barriers to healthcare. Feeder patterns are served, providing students with a medical and dental home from kindergarten through high school. Through transportation from feeder schools provided by the collaborating school districts, the Health Centers offer access to primary medical, mental health, nutritional and dental care services to underserved children. Medicaid is billed for enrolled students for eligible services; however, services are free for the uninsured and under-insured.

The scope of services offered at the six centers includes sick and injury care, general and sports physicals, immunizations, chronic care (asthma, obesity, cholesterol), mental health therapy and social service referrals, nutritional guidance, as well as other specific care to meet students’ needs. The Dental Clinics provide services that include periodic oral examinations, diagnostic x-rays, prophylaxis, fluoride treatments, oral hygiene instructions, sealants, amalgam and composite fillings, extractions, stainless steel crowns, pulpotomies, and root canals.

The Health Centers for Schools program provides readily accessible, primary healthcare, mental health, nutritional and dental care services to uninsured and underinsured children. The program does not collect cash, but bills for eligible services for Medicaid enrolled patients. (Mobile Dental Program does not presently bill). Students have a safe place to talk about sensitive issues; practitioners take their time addressing health problems that impede learning; the full spectrum of primary medical/ mental health/ and dental care is provided on site; and students and their families are continually educated on the importance of regular healthcare. The clinic's social worker and navigator also assist students' families in obtaining health, mental health and dental care not offered at the clinic and link families in need of basic services to community agencies.

Currently, Memorial Hermann has school based clinics in 3 school districts. Memorial Hermann believes there is a need for three additional clinics. This request proposes to expand the Memorial Hermann Health Centers for Schools program by 3 health centers and 1 mobile dental
van. One of these clinics may be added to a school district that already has an existing clinic; however, the new clinic will serve a distinct student population. These new school clinics will serve children who do not otherwise get healthcare. This expansion will result in serving approximately 18 additional schools, opening up access to approximately 15,000 additional students and providing approximately 9,500 visits.

**Goal(s) and relationship to Regional goal(s):**

**Project goals:**

The primary goal of this project is to bring increased primary care to school aged children, who will otherwise not obtain it. Furthermore, this care will be provided in school, so as not to disrupt their learning and development. This particular project will increase the number of school-based clinics providing primary medical, mental health, and dental care sites in low-income communities for children.

**This project meets the following Region 3 goals:**

This project addresses the RHP’s goal to “[i]ncrease access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.”

**Challenges and how addressed:**

This project has two primary challenges: (1) finding qualified professionals to staff the additional clinic; (2) reaching out to children and their parents to educate them about the benefits of the program. In order address these challenges, Memorial Hermann will engage in an aggressive strategy to recruit staff for the new clinics at the inception of the project and will prepare simple and effective educational materials to reach children and their parents.

**5-year expected outcome for provider and patients:**

This request proposes to expand the Memorial Hermann Health Centers for Schools program by 3 health centers and 1 mobile dental van. This expansion will result in serving approximately 18 additional schools, opening up access to approximately 15,000 additional students and providing approximately 9,500 visits. The clinics will operate Monday through Friday, 40 hours a week, twelve months a year. Memorial Hermann also expects to see improvement in certain clinical measures for the students engaged in the program such as: asthma exacerbations, emergency room visits, and hospitalizations.

- Asthma exacerbations, emergency room visits, and hospitalizations were reduced by 83% for the asthma population whose care is managed by the clinics. For students in the Healthy Eating and Lifestyle Program (HELP), 77% reduced their BMI. For students in the cholesterol program, 67% reduced their cholesterol. For students in the mobile dental program, 25% of children had caries at recall as compared to Healthy People 2020 Objectives which call for the proportion of children with one or more caries to be no more than 52% among children aged 4-11 and no more than 51% for adolescents aged 12+. Furthermore, .8% of established SBHC patients used an ER for
primary care purposes versus the community experience for uninsured patients of 10.5%. This reduction in ER usage equates to $199,005 in ER costs.

Starting Point/Baseline: Currently, Memorial Hermann has school based clinics in 3 school districts. Memorial Hermann believes there is a need to add three additional clinics. One of these clinics may be added to a school district that already has an existing clinic; however, they will serve distinct student populations. These new school clinics will serve children who do not otherwise get healthcare. Therefore, the baseline for clinic visits for the targeted population will start at 0.

Rationale:

In our current system, more often than not, children and teens receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated and comprehensive manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Families may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. Care may be foregone and or addressed only after medical and dental conditions have escalated. By enhancing access points by providing care where children and teens are located—at school—students and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Students perform better when they show up for class healthy and ready to learn. School-based health centers (SBHCs) ensure that kindergarteners through high schoolers can get a flu shot, have an annual physical, have their teeth examined and their eyes checked, or speak to a mental health counselor in a safe, nurturing place – without the barriers that families too often face. Memorial Hermann already has proven positive results with its existing program, which it wishes to expand upon. For example, in 2011:

- 9,125 children were served in 21,000 visits—84% were able to return to their classroom on the same day. (Schools receive $30 in federal support per child in attendance.)
- Asthma exacerbations, emergency room visits, and hospitalizations were reduced by 83%.
- 0.8% of SBHC patients used an ER for primary care purposes versus 10.5% of the general uninsured population under age 18 (source: Community Tracking Study, Medicaid/SCHIP Cuts and Hospital Emergency Department Use, Peter J. Cunningham).
- 67% of students with high cholesterol reduced their cholesterol; 50% achieved acceptable cholesterol levels.
- Students who received therapy from licensed clinical social workers: improved grade point averages: 2.7 to 3.2; reduced days absent: 1.5 to 1.0 days; and reduced detention/suspension incidents: 1.3 to 0.4 days.
- 25% of students seen in the mobile dental clinic had caries at recall as compared to Healthy People 2020 Objectives which call for the proportion of children with one or
more caries to be no more than 52% among children aged 4-11 and no more than 51%
for adolescents aged 12+.
- 93.1% of students with 3+ clinic visits for acute or chronic reasons receive a bi-
annual physical.
- 93.4% of sexually active youth decreased their high-risk behaviors by abstaining or
consistent use of birth control.

The program monitors measurable objectives in eight (8) categories: healthcare access (reduced
ER usage, increased time in the classroom); school performance (improved grades, reduced
absenteeism, reduced suspensions/detentions); asthma management (exacerbations/ER
visits/hospitalizations); cholesterol management (lipid levels); BMI (Body Mass Index); mental
health therapy (increased functional status); dental care (reduction of caries at recall); and
reproductive health behavior (decrease in at-risk behaviors). As each center becomes fully
operational, each of these outcome measures will be implemented and monitored.

Benchmarks are derived from the National Association of School Based Health Centers, The
Academy of Pediatrics, and Healthy People 2020. (Pre-post outcome data is also applied.)
Healthy People 2020 provides a framework for prevention for the Nation. It is a statement of
national health objectives designed to identify the most significant preventable threats to health
and to establish national goals to reduce these threats.

Project components:

The core project components include:

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

Unique community need identification number the project addresses:

- CN1 – Primary Care
- CN.4 - Inadequate access to dental care
- CN.6 - Inadequate access to treatment and services designed for special needs
populations, including disabled, homeless, children, elderly. Note: This statement is
true only as it applies to children.

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

Through this project Memorial Hermann will significantly enhance its ability to improve the
health outcomes of children in the community.

Related Category 3 Outcome Measure(s): OD-7: Oral Health;

IT 7.2 Cavities: Percentage of children with untreated dental caries (Healthy People 2020)
Reasons/rationale for selecting the outcome measure(s):

Rationale/Evidence: Children who have regular access to a dental provider are less likely to suffer from untreated dental caries

Relationship to Other Projects: This project is part of Memorial Hermann’s larger plans to expand and develop primary care and specialty care services, while improving access to care. Expanding primary care supports/reinforces several of the Category 1 and 2 projects: Increasing the number of nurse practitioners, licensed clinical social workers, and general dentists will have a direct impact on Expanding Primary Care Capacity (1.1); this project not only will increase the number of available nurse practitioners, licensed clinical social workers, and general dentists to participate in medical homes (2.1), it will also ensure that they are trained in the medical home concept; finally, the medical home concept of this program also reinforces the Redesign of Primary Care (2.3), the Redesign to Improve the Patient Experience (2.4).

Relationship to Other Performing Providers’ Projects in the RHP: Memorial Hermann Healthcare System reflects the vision of other Performing Providers’ in the RHP by increasing individual and families’ access to health, mental health and dental care, improving the quality of healthcare, reducing costly ED usage for primary care treatable issues, educating the community on alternative healthcare resources available to them and the importance of a medical and dental home, and reducing overall healthcare costs.

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

Project Valuation:

Approach for valuing project: The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

Rationale/justification for valuation: The expansion of primary care clinics for school aged children help address a substantial need in the community for increased access to primary care for one of the most vulnerable populations. It will also go a long way towards achieving the Waiver goal of improving outcomes while curbing the risk of healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes.
<table>
<thead>
<tr>
<th>020834001.1.1</th>
<th>1.1.1</th>
<th>A-C</th>
<th>ESTABLISH MORE PRIMARY CARE CLINICS: PRIMARY CARE EXPANSION SCHOOL BASED HEALTH</th>
</tr>
</thead>
</table>

Memorial Hermann Hospital System

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>020834001.3.1</th>
<th>IT-7.2</th>
<th>IT-1.1</th>
<th>Cavities: Percentage of children with untreated dental cavities (Healthy People 2012) Third next available appointment</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

Milestone 1 [P-X]:
Determine which schools and school districts in need of additional school health centers.

Metric 1 [P-X]: Conduct needs assessment to determine areas most in need of school based health clinics.

Baseline/Goal: To establish process to target most underserved schools.

Data Source: Project plan that describes target population at particular schools for additional school clinics.

Milestone 2
P-X: Establish baseline for existing primary care clinic volume, number of primary healthcare workers and staff.

Metric
Establish baseline for future years.

Data Source:
Submission of documentation demonstrating study of baseline numbers.

Milestone 3
CQI: P-3 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects

Metric
CQI: P-3.1 Number meetings, conference calls or webinars organized by the RHP that the provider participated in.

Data Source
Meeting Agendas, sign-in sheets, conference calls, presentations, email

Milestone 4 [P-5]:
Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers.

Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites.

Milestone 5
CQI: P-3 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects

Metric
CQI: P-3.1 Number meetings, conference calls or webinars organized by the RHP that the provider participated in.

Data Source
Meeting Agendas, sign-in sheets, conference calls, presentations, email

Milestone 6 [P-5]:
Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers.

Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites.

Milestone 8 [I-15]:
Increase access to primary care capacity.

Metric 1 [I-15.1]: Increase percentage of target population reached.

Goal: To reach at least 15% more of targeted population as identified by analysis in DY2

Data Source: Documentation of target population reached, as designated in the project plan.

Milestone 9 [I-12]:
Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.

Baseline/Goal: 9,500 medical/social work and dental visits for all 3 SBHCs combined.

Data Source: Registry, EHR, or other Performing Provider source.
### Establish More Primary Care Clinics: Primary Care Expansion School Based Health

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>020834001.3.1</th>
<th>IT-7.2</th>
<th>IT-1.1</th>
<th>Cavities: Percentage of children with untreated dental cavities (Healthy People 2012) Third next available appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal:</strong></td>
<td></td>
<td></td>
<td></td>
<td>To determine baseline for measure of project improvement in future years.</td>
</tr>
<tr>
<td><strong>Baseline/Goal:</strong></td>
<td></td>
<td></td>
<td></td>
<td>5% increase over DY 2 baseline.</td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Documentation of completion of all items described by the RHP plan for this measure; hospital or other Performing Provider report, policy, contract, or other documentation.</td>
</tr>
<tr>
<td><strong>Baseline/Goal:</strong></td>
<td></td>
<td></td>
<td></td>
<td>10% increase over DY 2 baseline.</td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Documentation of completion of all items described by the RHP plan for this measure; hospital or other Performing Provider report, policy, contract, or other documentation.</td>
</tr>
<tr>
<td><strong>Milestone 7 [I-12]:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
</tr>
<tr>
<td><strong>Metric 1 [I-12.1]:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Documentation of increased number of visits. Demonstrate improvement over prior reporting period.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Baseline/Goal: 7000 medical/social work/and dental visits for all 3 SBHCs combined.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Data Source: Registry, EHR, or other Performing Provider source.</td>
</tr>
<tr>
<td>020834001.1.1</td>
<td>1.1.1</td>
<td>A-C</td>
<td>ESTABLISH MORE PRIMARY CARE CLINICS: PRIMARY CARE EXPANSION SCHOOL BASED HEALTH</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>--------</td>
<td>-----</td>
<td>--------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>020834001.3.1</td>
<td>IT-7.2</td>
<td>Cavities: Percentage of children with untreated dental cavities (Healthy People 2012) Third next available appointment</td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $3,603,461</td>
<td>Year 3 Estimated Milestone Bundle Amount: $3,931,183</td>
<td>Year 4 Estimated Milestone Bundle Amount: $3,942,611</td>
<td>Year 5 Estimated Milestone Bundle Amount: $3,256,939</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $14,734,194
**Project Option:** 1.6.2 24-Hour Nurse Triage Line  
**Performing Provider:** Memorial Hermann Hospital System/TPI 020834001  
**Unique Project ID:** 020834001.1.2

- **Provider:** Memorial Hermann Hospital System (Memorial Hermann) is a 1,164 bed hospital system consisting of 4 campuses in the Houston-Sugarland-Baytown MSA. The system serves a population of approximately 6,000,000 people.

- **Intervention(s):** Memorial Hermann will implement a region-wide 24-hour nurse triage line that will assist patients considering an ER visit in determining what level of care they need to access and connect them to an appropriate resource. The goal is to ensure efficient use of the system’s ER department and reduce unnecessary visits.

- **Need for the project:** Over 48% of all emergency room patients treated and released in Harris County are primary care treatable. These visits result, in part, because patients do not have the clinical knowledge to assess their condition and unnecessarily visit the ER. Once the 24-hour Nurse Triage Line is in place, it is anticipated that the demand for the ER will decline and more significantly, there will be a reduction in inappropriate demand.

- **Target population:** The target population is any patient in the region that is considering an ER visit. Incoming calls are anticipated to be from uninsured and insured individuals and represent both urgent and non-urgent health care situations. The 24-hour Nurse Triage Line will reduce costs and improve access to care for uninsured and Medicaid populations by recommending to patients the most suitable intensity of care and connecting them to that care through CHWs. This will result in more appropriate utilization of facilities reducing expenditures for uncompensated care and better serving managed care patients within financial limitations.

- **Category 1 or 2 expected patient benefits:** Based on the information currently available, Memorial Hermann expects to reach approximately 61,000 patient calls by the final year of the project as follows:

  - DY3: 26,280 calls/pts (3 calls per hour)
  - DY4: 43,800 calls/pts (5 calls per hour)
  - DY5: 61,320 calls/pts (7 calls per hour)

  Memorial Hermann expects that 12% of the population reached will be Medicaid and 24% of the population reached will be indigent. (Data Source: The State of Health of Houston/Harris County, 2009; Center for Houston’s Future: Healthy Communities Indicator Report 2013).

- **Category 3 outcomes:** IT 9.2 - In DY5, Memorial Hermann intends to improve the ER diversion rate among individuals calling the Nurse Triage Line by 25% from by the baseline measured in DY 2.
**Title: 24 HOUR NURSE TRIAGE LINE**

**Unique RHP Project Identification Number:** 020834001.1.2

**Performing Provider Name/TPI:** Memorial Hermann Hospital System/TPI 020834001

**Project Description 1.6/1.6.2:**

Implement a region-wide 24 Hour Nurse Triage Line, seven days a week that will assist patients residing in the region, who are considering an ER visit, in determining what level of care they need to access and connect them to an appropriate resource. Twelve FTE dedicated triage nurses will manage the hotline at all times full implementation. Six triage clerks and 5 Community Health Workers (“CHWs”) will provide support to the program. Nurses will be added as call volume dictates and adjusted during peak intervals. After listening to a caller’s concerns, the nurse will provide guidance on whether or not an ED visit is warranted. If an ED visit is not necessary, the nurse will refer the caller to a CHW who will arrange an appointment at a nearby urgent care center, federally qualified health center (FQHC), or physician’s office. CHWs will follow up with all patients within 24 hours to ensure they have attended or plan to attend their scheduled appointments. Bilingual services will be provided as needed.

Memorial Hermann’s Nurse Triage Line project is designed to serve the entire region, regardless of callers’ current healthcare affiliations, significantly expanding the services offered by the previous Ask Your Nurse line to meet the growing healthcare needs of the region. Incoming calls are anticipated to be from uninsured and insured individuals and represent both urgent and non-urgent healthcare situations. The CHW’s will navigate all primary care treatable calls to appropriate private and safety-net providers in the region taking into account a caller’s health care needs, insurance status, income level, location and language. Memorial Hermann has a highly, successful ER Navigator program and anticipates applying those best practices to the CHW’s processes for this project.

**Goal(s) and relationship to Regional goal(s):**

**Project Goal:**

Provide medical advice to callers and help them determine the appropriate place for them to receive that care. If it is determined that they do not need emergency care, they will be connected to the appropriate resource. Data will be captured on the number of calls redirected from the emergency room, and the number of callers who sought care in the suggested alternative.

This project meets the following Region 3 goals:

This project addresses the RHP’s goal to “[i]ncrease access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.”
**Challenges and how addressed:**

The key challenge in implementing this project will be the hiring and training of staff. To address this challenge, Memorial Hermann will establish training programs in the initial stages of implementing this project.

**5-year expected outcome for provider and patients:**

Memorial Hermann will aim to significantly expand the use of the nurse call line in order to reach as many as 61,000 patients in a 12 month period.

**Starting Point/Baseline:**

Memorial Hermann intends to benchmark on the outcomes of the previous community-wide Ask Your Nurse triage line. This service operated from 2003 to 2011 in Harris County.

**Rationale:**

Over 48% of all emergency room visits in Harris County are primary care treatable. These visits result, in part, because people do not have the clinical knowledge to assess the nature of their illness or are unaware that other resources are available in the community. When Harris County had a community nurse triage line, data showed that 1 out of every 4 nurse triage callers was redirected from an emergency center. This nurse triage line will also be staffed with navigators who can connect the patient to an alternative source for care, thus breaking the ER cycle and the significant costs associated with that care. The line will be a 1-800 number so that it can serve the whole region and be staffed to handle the call volume. Since the service did exist in Harris County, many of the avenues for distribution of the number (such as insert with water bills, posters and cards in ERs and clinics, and many other avenues) can be used again.

Once the 24-hour Nurse Triage Line is in place, it is anticipated that demand for the ED will decline and more significantly, there will be a reduction in inappropriate demand. Based on historical experience, projections indicate that approximately half of the calls will be triaged to lower-level care settings. Routing patients to a lower level of care reduces patient costs. Indirect impact includes reducing bad debt from non-emergent ED patients. This free telephone service will help patients avoid long waits and unnecessary expense at area EDs. Over time, by associating a care coordination and navigation component through the CHWs, it is reasonable to project that the health status of individuals connecting through the system will also result in additional documentable savings related to hospital admissions and readmissions when compared to a stratified sample of patients that match the demographics of those using the service.

**Project components:**

**Required core project components:**

a) Develop a process (including a call center) that in a timely manner triages patients seeking primary care services in an ED to an alternate primary care site. Survey patients who use the nurse advice line to ensure patient satisfaction with the services received.
- Memorial Hermann will develop processes and procedures in this call center to triage patients and ensure they are cared for in the most appropriate setting. Memorial Hermann will also encourage patients to participate in surveys to monitor their satisfaction.

b) Enhance linkages between primary care, urgent care, and Emergency Departments in order to increase communication and improve care transitions for patients.

- The staff at the patient call center will be able to directly facilitate transfer and communication between EDs, urgent cares, and primary care sites of service.

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

- Memorial Hermann will conduct ongoing quality improvement processes in order to continually and effective manage the program.

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

- CN1 – Primary Care
- CN.7 – Insufficient access to care coordination practice management and integrated care treatment programs

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

By introducing a region-wide, 24 Hour Nurse Triage Line, Memorial Hermann is implementing a new initiative designed to assist all callers regardless of their current insurance status and/or current healthcare affiliations, thus reaching many more patients in need. The project represents a significant benefit to the community both in educating consumers about accessing appropriate healthcare facilities for primary care treatable conditions and reducing healthcare costs across the region. The Memorial Hermann 24 Hour Nurse Triage Line will increase the capacity of the region to provide appropriate, less costly, alternative healthcare solutions that will enhance our current service offerings and impact systemic change across the region as consumers become more informed about their healthcare options.

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

OD-9: Right Care, Right Setting; IT-9.2: ED Appropriate Utilization
Reasons/rationale for selecting the outcome measure(s):

The 24 Hour Nurse Triage Line will allow patients to speak with a healthcare professional who can advise them and direct them to seek appropriate care. This will directly reduce the number of patients seeking that advice from the ED or other inappropriate sites of care.

Relationship to other Projects: This project is part of Memorial Hermann’s larger plans to expand and develop primary care and specialty care services, while improving access to care and containing the costs of care.

Relationship to Other Performing Providers’ Projects in the RHP: Memorial Hermann Healthcare System reflects the vision of other Performing Providers’ in the RHP by increasing individual and families’ access to healthcare, improving the quality of healthcare, reducing costly ED usage for primary care treatable issues, educating the community on alternative healthcare resources available to them and the importance of a medical home, and reducing overall healthcare costs.

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

Project Valuation:

Approach for valuing project: The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served (both number of people and complexity of patient needs), the alignment with community needs, the magnitude of costs avoided or reduced, the degree collaboration involved, and the sustainability of the project.

Rationale/justification for valuation: The Nurse advice line has already proven its ability to lower healthcare costs. In addition, the expansion of the line will increase patient satisfaction and health outcomes as they receive the right care in the right setting. The reduction of costs and the increase in health outcomes are cornerstone issues under the Waiver.
**Milestone 1** [P-2]:
Collect baseline data to track access for specified patient population.

**Metric [P-2.1]:** Documentation of baseline assessment
Baseline/Goal: To analyze current demographics of patients utilizing Houston ERs for PCR purposes.
Data Source: UTSPH ER Algorithm Study.

**Milestone 1** [P-4]: Establish nurse advice line to increase access to patients based on need within the RHP.

**Milestone 3** [P-4]:
Expand nurse advice line by 10% to increase access to patients based on need within the RHP.

**Metric [P-4.1]:** Number of nurses staffing nurse advice line per shift
Baseline/Goal: To increase the number of nurses available per shift by 10%
Data Source: Documentation of nurse advice line staffing levels.

**Milestone 4**
CQI: P-8 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects
Metric

**CQI: P-8.1** Number meetings, conference calls or webinars organized by the RHP that the provider

**Milestone 5** [I-13]:
Increase in the number of patients that access the call center.
Metric 1 [I-13.1]: Utilization of call center.
Goal: Increase utilization by 5% over baseline in DY2. (Expected total of approximately 43,000 calls by DY 4)
Data Source: Call logs. The triage line software will record the # of calls received, the # of calls abandoned, track nurse recommendations and referrals and CHW follow-up activities.

**Milestone 6**
CQI: P-8 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects

**Metric**

**CQI: P-8.1** Number meetings, conference calls or webinars organized by the RHP that the provider

**Milestone 8** [I-13]:
Increase in the number of patients that access the call center.
Metric 1 [I-13.1]: Utilization of call center.
Goal: Increase utilization by 10% over baseline in DY2.
(Expected total of approximately 61,320 calls by DY 5)
Data Source: Call logs. The triage line software will record the # of calls received, the # of calls abandoned, track nurse recommendations and referrals and CHW follow-up activities.

**Milestone 9** [P-4]:
Expand nurse advice line by 20% based on baseline data to increase access to patients based on need within the RHP.

**Metric [P-4.1]:** Number of nurses staffing nurse advice line per shift
Baseline/Goal: To increase the number of nurses available per shift by 20%
<table>
<thead>
<tr>
<th>Outcome Measure(s):</th>
<th>020834001.3.2</th>
<th>IT-9.2</th>
<th>ED Appropriate Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Participated in.**

**Data Source:**
- Meeting Agendas, sign-in sheets, conference calls, presentations, email
- Data Source

**Milestone 7[P-4]:**
Expand nurse advice line by 15% based on baseline data to increase access to patients based on need within the RHP.

**Metric 1[P-4.1]:** Number of nurses staffing nurse advice line per shift

**Baseline/Goal:** To increase the number of nurses available per shift by 15%

**Data Source:** Documentation of nurse advice line staffing levels

**Year 2 Estimated Milestone Bundle Amount:** $3,406,011

**Year 3 Estimated Milestone Bundle Amount:** $3,715,776

**Year 4 Estimated Milestone Bundle Amount:** $3,726,577

**Year 5 Estimated Milestone Bundle Amount:** $3,078,477

**Total Estimated Incentive Payments for 4-Year Period:** $13,926,841
**Project Option:** 1.12.2 Home Health Psych Services  
**Performing Provider:** Memorial Hermann Hospital System/TPI 020834001  
**Unique Project ID:** 020834001.1.3

- **Provider:** Memorial Hermann Hospital System (Memorial Hermann) is a 1,164 bed hospital system consisting of 4 campuses in the Houston-Sugarland-Baytown MSA. The system serves a population of approximately 6,000,000 people.

- **Intervention(s):** Memorial Hermann proposes to expand home health service to include psychiatric services. The program would include specialized training and certifications for nurses and the addition of social work services to link clients to additional community care programs. The goal of the project would be to provide support of those patients with mental health issues, to better manage their care in the home and community, and reduce the number of visits to emergency departments for psychiatric care that could be managed in the home/community environment.

- **Need for the project:** Texas ranks 49th in state per capita mental health funding, and Harris County (greater Houston) ranks among the lowest in Texas counties. One of every five Houstonians (665,000) has a mental illness. Of these, 181,690 have a serious mental illness. About 20 percent, or 435,352 of adults aged 18 to 54 will have a mental disorder during a given year. A smaller subgroup of nine percent, or 195,908, of Houstonians will have a mental disorder and will experience at least transitory impairment.

- **Target population:** The target population is patients who 1) use hospital ERs for non-emergent treatment for psychiatric diagnosis, 2) admit to hospitals for medical and/or psychiatric diagnosis and do not have safe/effective discharge plans so an unnecessary readmission occurs, 3) admit to hospitals are treated and stabilized and stay in a hospital longer than required because a lack of community resources to address psychiatric diagnoses exists.

- **Category 1 or 2 expected patient benefits:** The psychiatric home health program in year one of operation would be able to admit up to 800 patients on to service. By DY5 patients utilizing the psychiatric home health program will increase by 15% over baseline.

Over the course project Memorial Hermann expects to have approximately 3,000 patient visits as a result of this project as follows:

- 800 patient visits in DY 3
- 880 patient visits in DY 4
- 920 patient visits in DY 5

Memorial Hermann expects approximately 65% of these patients to be on Medicaid and approximately 25% of these patients to be indigent.
- **Category 3 outcomes**: IT 3.8 Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate will experience a 10% reduction in DY5 over the baseline in DY5.
Title: Home Health Psych Services

Unique RHP Identification Number: 020834001.1.3

Performing Provider Name/TPI: Memorial Hermann Hospital System/TPI 020834001

Project Description 1.12/1.12.2: Memorial Hermann proposes to expand home health service to include psychiatric services. The program would include specialized training and certifications for nurses and the addition of social work services to link clients to additional community care programs. Both program additions help to better manage psychiatric patients in the home setting. Memorial Hermann has identified a significant need for additional resources in the discharge planning process for individuals with behavior health needs. Currently, these individuals are discharged without appropriate home care services or are linked with home care agencies that do not have expertise and training to care for this specific population.

We are aiming to serve the population of patients who 1) use hospital ER’s for non-emergent treatment for psychiatric diagnosis, 2) admit to hospitals for medical and/or psychiatric diagnosis and do not have safe/effective discharge plans so an unnecessary readmissions occurs, 3) admit to hospitals are treated and stabilized, but stay in a hospital setting longer than required because a lack of community resources to address psychiatric diagnosis exists.

Goal(s) and relationship to Regional goal(s):

Project Goals:

Texas proposes to take specific steps to broaden access to care that will include an expansion of community-based service options. The goal of psychiatric home services would be to provide support to those patients with a mental health issue, to better manage their care in the home and community, and reduce the number of visits to emergency departments for psychiatric care that could be managed in the home/community environment.

This project meets the following Region 3 goals:

This project addresses the RHP’s goal to “[d]evelop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.”

Challenges and how addressed:

The challenges in implementing a psychiatric home health program are: 1) the organization’s ability to recruit and retain qualified staff to operate the program and provide clinical care to the psychiatric population, 2) the population’s payor mix and high volume of uninsured, 3) the organization’s ability to develop standard metrics and comparison data specific to the psychiatric population, 4) the organization’s ability to educate and gain program support from physicians, 5) the organization’s ability to efficiently obtain industry required documentation and signatures from physicians.
**5-year expected outcome for provider and patients:**

Memorial Hermann has calculated an assumption that a psychiatric home health program in year one of operation would be able to admit up to 800 patients on to service. Memorial Hermann expects that once the project is fully operational, it will be able to admit up to 800 patients to this service every year.

**Starting Point/Baseline:** Memorial Hermann does not currently have a comprehensive service to psychiatric services delivered at home.

**Rationale:**

Positive healthcare outcomes are contingent on the ability of the patient to obtain both routine examinations and healthcare services as soon as possible after a specific need for care has been identified. However, many Texans are unable to access either routine services or needed care in a timely manner either because they lack transportation or because they are unable to schedule an appointment due to work scheduling conflicts (or school scheduling conflicts in the case of children) or because they have obligations to provide care for children or elderly relatives during normal work hours. While such barriers to access can compromise anyone’s ability to make or keep scheduled appointments, individuals with behavioral health needs may be especially negatively affected. Many individuals with behavioral health needs are reticent to seek treatment in the first place and such barriers may be sufficient to prevent access entirely. Others may be easily discouraged by such barriers and may drop out of treatment. Any such delay in accessing services or any break or disruption in services may result in functional loss and the worsening of symptoms. These negative health outcomes come at great personal cost to the individual and also result in increased costs to payers when care is finally obtained.

**Project components:**

There are no required components for this project option.

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

- CN.3 -- Inadequate access to behavioral health care

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

This project represents a fundamental change in the manner by which Memorial Hermann will deliver behavioral health services. By delivering care in the home Memorial Hermann will be increasingly efficient in caring for our patients and will increase overall patient satisfaction.

**Related Category 3 Outcome Measure(s):** OD-3: Potentially Preventable Re-Admissions – 30 day Readmission Rates; Establish Baseline Rates; IT 3.8 Behavioral Health/Substance Abuse 30 day readmission rate.

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

The increase in health outcomes, which is a proven result of delivering services in the home, will decrease potentially preventable re-admissions.
Relationship to other Projects: This project is part of Memorial Hermann’s larger plans to expand and develop primary care and specialty care services, while improving access to care and implementing delivery improvements targeted to specific populations (in this case, behavioral health patients).

Relationship to Other Performing Providers’ Projects in the RHP: TBD

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

Project Valuation:

Approach for valuing project: The valuation of Memorial Hermann’s projects use a method which ranks the importance of each projects based several key factors. First, Memorial Hermann considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, Memorial Hermann considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, Memorial Hermann reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

Rationale/justification for valuation: This project’s value is justified by the fact that it directly addresses one of the most fundamental and unmet healthcare needs in Harris County and in Region 3 generally, behavioral health. It also empowers patients by delivering services to them at home.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>020834001.3.3</th>
<th>IT-3.8</th>
<th>Behavioral Health/Substance Abuse (BH/SA) 30-Day Readmission Rate</th>
</tr>
</thead>
</table>

**Milestone 1**

- **P-X**: Establish baseline for number of staff for community based behavioral health services, number of patients reached by community based behavioral health services, and number of sites for community based behavioral healthcare delivery.

**Metric**

- Establish baseline for future years.

**Data Source:**

Submission of documentation demonstrating study of baseline numbers.

**Goal:**

To determine baseline for measure of project improvement in future years.

**Milestone 1 Estimated Incentive Payment:** $2,048,543.00

**Milestone 2**

- **CQI**: P-8 Participate in interactions

**Milestone 3**: P-3 (Develop administrative protocols and clinical guidelines for project)

**Metric**

- P-3.1: Manual of operations for the project detailing administrative protocols and clinical guidelines

**Baseline/Goal**: Completion of protocol manual

**Data Source**: The manual

**Milestone 3 Estimated Incentive Payment**: $1,117,425.25

**Milestone 4**: P-4 (Hire and train staff to operate the project)

**Metric 1**: (P-4.1) Number of staff secured and trained

**Baseline/Goal**: Increase staffing 5% over baseline

**Data Source**: Project records and training guides.

**Milestone 4 Estimated Incentive Payment**: $1,117,425.25

**Milestone 5**

- **CQI**: P-8 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects

**Metric**

- P-8.1 Number meetings, conference calls or webinars organized by the RHP that the provider participated in.

**Data Source**: Meeting Agendas, sign-in sheets, conference calls, presentations, email

**Milestone 5 Estimated Incentive Payment**: $1,851,547.50

**Milestone 6**

- **CQI**: P-8.1 Number meetings, conference calls or webinars organized by the RHP that the provider participated in.

**Metric**

- P-8.1.1 Percent utilization of community behavioral healthcare services.

**Goal**: Increase community utilization of community based healthcare services by 15% over baseline

(Approximately 920 visits)
**Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Home Health Psych Services**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>020834001.3.3</th>
<th>IT-3.8</th>
<th>Behavioral Health/Substance Abuse (BH/SA) 30-Day Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Memorial Hermann Hospital System</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td>10/1/2012 – 9/30/2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong></td>
<td>10/1/2013 – 9/30/2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong></td>
<td>10/1/2014 – 9/30/2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong></td>
<td>10/1/2015 – 9/30/2016</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

with other providers and RHP to promote collaborative learning around shared or similar projects

**Metric**

**CQI: P-8.1** Number meetings, conference calls or webinars organized by the RHP that the provider participated in.

**Data Source**

Meeting Agendas, sign-in sheets, conference calls, presentations, email

Milestone 2 Estimated Incentive Payment: $2,048,543.00

**Milestone 5**

**CQI: P-8** Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects

**Metric**

**CQI: P-8.1** Number meetings, conference calls or webinars organized by the RHP that the provider participated in.

**Data Source:** Meeting Agendas, sign-in sheets, conference calls, presentations, email.

Milestone 5 Estimated Incentive Payment: $1,117,425.25

10% over baseline

(Approximately 880 visits)

**Data Source:** Claims data and encounter data from community behavioral health sites and expanded transportation programs.

Milestone 8 Estimated Incentive Payment: $1,494,231.33

**Milestone 9:** P-6 Establish behavioral health services in new community-based settings in underserved areas

**Metric** [P-6.1]: Number of new community-based settings where behavioral health services are delivered

**Baseline/Goal:** 10% increase in community based sites over DY2 baseline.

**Data Source:** Patient and project records.

Milestone 9 Estimated Incentive Payment: $1,494,231.33

Data Source: Claims data and encounter data from community behavioral health sites and expanded transportation programs.

Milestone 11 Estimated Incentive Payment: $1,851,547.50
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline/Goal</strong>: 5% increase in community based sites over DY2 baseline.</td>
<td><strong>Data Source</strong>: Patient and project records.</td>
<td><strong>Milestone 6 Estimated Incentive Payment</strong>: $1,117,425.25</td>
<td></td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount**: $4,097,086  
**Year 3 Estimated Milestone Bundle Amount**: $4,469,701  
**Year 4 Estimated Milestone Bundle Amount**: $4,482,694  
**Year 5 Estimated Milestone Bundle Amount**: $3,703,095

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**: $16,752,577
**Project Option:** 1.1.2 Expand Existing Primary Care Capacity: Convenient Care Centers  
**Performing Provider:** Memorial Hermann Hospital System/TPI 020834001  
**Unique Project ID:** 020834001.1.4

- **Provider:** Memorial Hermann Hospital System (Memorial Hermann) is a 1,164 bed hospital system consisting of 4 campuses in the Houston-Sugarland-Baytown MSA. The system serves a population of approximately 6,000,000 people.

- **Intervention(s):** Memorial Hermann will create neighborhood centers that integrate all ambulatory services in a highly coordinated, efficient and accessible manner for the greater Houston MSA. The goal of the project is to expand the capacity of primary care to better accommodate the needs of the regional patient population and community.

- **Need for the project:** In the greater Houston MSA, patients often receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care.

- **Target population:** The target population is patients in the greater Houston MSA that would benefit from seeking primary care at an ambulatory facility as opposed to an acute care facility. It is estimated that 37.55% of the patients in Memorial Hermann’s service area are either Medicaid eligible or uninsured and rely on Memorial Hermann’s and other hospitals emergency department for primary care services.

- **Category 1 or 2 expected patient benefits:**
  
  Over the course of the project, Memorial Hermann expects approximately 35,300 patient visits as a result of this project as follows:

  11,000 patient visits in DY 3  
  11,900 patient visits in DY 4  
  12,400 patient visits in DY 5

  Memorial Hermann expects approximately 7-10% of these patients will be Medicaid or indigent.

  **Category 3 outcomes:** IT-1.10 Diabetes care: HBA1c poor control (>9.0%)
Project Option- 1.1.2 Expand existing primary care capacity: Convenient Care Centers

Unique RHP Project Identification Number: 020834001.1.4

Performing Provider Name/TPI: Memorial Hermann Hospital System (Memorial Hermann) /020834001

Project Description: Create neighborhood centers that integrate all ambulatory services in a highly coordinated, efficient and accessible manner (imaging, emergency care, Primary Care, Specialty Care, Lab, Therapy, and Pharmacy for the Greater Houston Metropolitan Statistical area targeting pediatric and adult primary care patients.

Goal(s) and relationship to Regional goal(s):

Project goals:

Expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.

This project meets the following Region 3 goals:

This project addresses the RHP’s goal to “[i]ncrease access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.”

Challenges and how addressed:

The key challenges facing the implementation of this project are the recruitment and locating appropriate space. Memorial Hermann will address these challenges by putting in place an aggressive recruitment effort and identifying possible locations in the early stages of the project.

5-year expected outcome for provider and patients:

Memorial Hermann expects that his project will significantly increase access to primary care for pediatric and adult primary care patients in the Greater Houston Metropolitan Statistical Area.

Starting Point/Baseline: The creation of a convenient care center network is a new initiative and as such will require the creation of a baseline as an early milestone for the project.

Rationale:

Reasons for selecting the project option: In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned
provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization, and reduced cost of services.

**Project components:**

Required core project components:

a) Expand primary care clinic

-Memorial Hermann will increase sites of the primary care network in the Greater Houston Metropolitan Statistical Area.

b) Expand availability of primary care clinic hours

- Memorial Hermann will expand clinic hours in the Greater Houston Metropolitan Statistical Area, eventually moving to 24 hour, 7 day per week primary care availability.

c) Expand primary care provider availability

- Memorial Hermann will recruit additional primary care physicians and clinical extenders (nurse practitioners and physician assistants) to staff the primary care network.

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

- CN.1 - Primary Care
- CN.8 - High rates of inappropriate emergency department utilization
- CN.9 - High rates of preventable hospital readmissions
- CN.6 - Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, and elderly

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

This project would significantly enhance Memorial Hermann’s ability to deliver vital healthcare services. Moreover, this is a new initiative for Memorial Hermann and, to our knowledge, Harris County. Therefore, this project will be highly contributive to the reform of the delivery system in Region 3.

**Related Category 3 Outcome Measure(s): Reasons/rationale for selecting the outcome measure(s):**

- IT-1.10 Diabetes care: HBA1c poor control (>9.0%)
**Relationship to other Projects:** This project is part of Memorial Hermann’s larger plans to expand and develop primary care and specialty care services, while improving access to care.

**Relationship to Other Performing Providers’ Projects in the RHP:** TBD

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

**Project Valuation:**

**Approach for valuing project:** The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

**Rationale/justification for valuation:** A convenient care center will promote better access to services for many patients who cannot reliably travel between many disparate healthcare providers to receive services. This increased efficiency should lead to better health outcomes in the community which justifies the valuation of this project.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>020834001.3.4</th>
<th>IT-1.10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong></td>
<td></td>
<td>(10/1/2012 – 9/30/2013)</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 1</strong></td>
<td>Process P-X: Establish baseline for measures P-1, P-4, P-5, I-11, and I-12. This milestone will be a comprehensive assessment of all the baseline data that will be necessary to measure the future success of the project/</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric</strong>: Submission of baseline assessment documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal</strong>: To establish baseline for future years.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Provider documentation of baseline study</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 2</strong></td>
<td><strong>CQI</strong>: P-1 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric</strong>:</td>
<td><strong>CQI</strong>: P-1.1 Number meetings, conference calls or webinars organized by the RHP that the provider participated in.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
<td>Meeting Agendas, sign-in sheets, conference calls, presentations, email</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3</strong></td>
<td><strong>CQI</strong>: P-1 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric</strong>:</td>
<td><strong>CQI</strong>: P-1.1 Number meetings, conference calls or webinars organized by the RHP that the provider participated in.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
<td>Meeting Agendas, sign-in sheets, conference calls, presentations, email</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 4</strong></td>
<td><strong>P-4</strong>: Expand the hours of a primary care clinic, including evening and/or weekend hours.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1 [P-4.1]</strong>: Increased number of hours at primary care clinic over baseline.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5</strong></td>
<td><strong>CQI</strong>: P-1 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric</strong>:</td>
<td><strong>CQI</strong>: P-1.1.1 Number meetings, conference calls or webinars organized by the RHP that the provider participated in.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
<td>Meeting Agendas, sign-in sheets, conference calls, presentations, email</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 6</strong></td>
<td><strong>CQI</strong>: P-1 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric</strong>:</td>
<td><strong>CQI</strong>: P-1.1.1 Number meetings, conference calls or webinars organized by the RHP that the provider participated in.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
<td>Meeting Agendas, sign-in sheets, conference calls, presentations, email</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 7</strong></td>
<td><strong>P-4</strong>: Expand the hours of a primary care clinic, including evening and/or weekend hours.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1 [P-4.1]</strong>: Increased number of hours at primary care clinic over baseline.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 8</strong></td>
<td><strong>I-11</strong>: Patient satisfaction with primary care services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1 [I-11.1]</strong>: Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores. Demonstrate improvement over prior reporting period.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: 4% improvement.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: CG-CAHPS or other developed evidence-based satisfaction assessment tool, available in formats and language to meet patient population.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 2 [I-11.2]</strong>: Percentage of patients receiving survey. Specifically, the percentage of patients that are provided the opportunity to respond to the survey. Demonstrate improvement over prior reporting period.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: 10% improvement.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Performing provider documentation of survey distribution; EHR.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 9</strong></td>
<td><strong>P-4</strong>: Expand the hours of a primary care clinic, including evening and/or weekend hours.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1 [P-4.1]</strong>: Increased number of hours at primary care clinic over baseline.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 10</strong></td>
<td><strong>I-11</strong>: Patient satisfaction with primary care services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1 [I-11.1]</strong>: Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores. Demonstrate improvement over prior reporting period.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: 4% improvement.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: CG-CAHPS or other developed evidence-based satisfaction assessment tool, available in formats and language to meet patient population.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 2 [I-11.2]</strong>: Percentage of patients receiving survey. Specifically, the percentage of patients that are provided the opportunity to respond to the survey. Demonstrate improvement over prior reporting period.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: 10% improvement.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Performing provider documentation of survey distribution; EHR.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 11</strong></td>
<td><strong>P-4</strong>: Expand the hours of a primary care clinic, including evening and/or weekend hours.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1 [P-4.1]</strong>: Increased number of hours at primary care clinic over baseline.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 12</strong></td>
<td><strong>I-11</strong>: Patient satisfaction with primary care services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1 [I-11.1]</strong>: Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores. Demonstrate improvement over prior reporting period.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: 4% improvement.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: CG-CAHPS or other developed evidence-based satisfaction assessment tool, available in formats and language to meet patient population.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 2 [I-11.2]</strong>: Percentage of patients receiving survey. Specifically, the percentage of patients that are provided the opportunity to respond to the survey. Demonstrate improvement over prior reporting period.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: 10% improvement.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Performing provider documentation of survey distribution; EHR.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 020834001.1.4 | 1.1.2 | 1.1.2 A-C | **EXPAND EXISTING PRIMARY CARE CAPACITY: CONVENIENT CARE CENTERS**

**Memorial Hermann Hospital System**

| Related Category 3 Outcome Measure(s): | 020834001.3.4 | **IT-1.10** | **Diabetes Care : HbA1c poor control (<9.0%)-NQF 0059 Stand Alone Measure**

| Year 2 | Year 3 | Year 4 | Year 5 |

**Data Source**
- Meeting Agendas, sign-in sheets, conference calls, presentations, email
- Data Source: Clinic documentation.
- Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider.
- Data Source: Documentation of completion of all items described by the RHP plan for this measure; hospital or other Performing Provider report, policy, contract, or other documentation.

**Milestone 2**
- Estimated Incentive Payment: $419,253

**Milestone 5** [P-1]:
- Establish additional/expand existing/relocate primary care clinics.

**Metric 1** [P-1.1]: Number of additional clinics or expanded hours or space.
- Baseline/Goal: 1 primary care clinic. (Estimated goal is to have 2 PCP Clinics)
- Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider.

**Milestone 6** [P-1.5]:
- Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers.

**Metric 1** [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites.
- Baseline/Goal: Addition of 1 primary care clinic/provider. (Estimated goal is 4 PC Providers; 7 staff)
- Data Source: Documentation of completion of all items described by the RHP plan for this measure; hospital or other Performing Provider report, policy, contract, or other documentation.

**Milestone 7** [I-11]:
- Patient satisfaction with primary care

**CQI: P-1**
- Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects

**Metric**

**CQI: P-1.1**
- Number meetings, conference calls or webinars organized by the RHP that the provider participated in.

**Data Source**
- Meeting Agendas, sign-in sheets, conference calls, presentations, email

**Milestone 12** [I-12]:
- Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1** [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.
- Baseline/Goal: 5% increase over DY 2 baseline. (Approximately 12,400 visits)
- Data Source: Registry, EHR, claims, or other Performing Provider source.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>020834001.3.4</th>
<th>IT-1.10</th>
<th><strong>Diabetes Care : HbA1c poor control (&lt;9.0%)-NQF 0059 Stand Alone Measure</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td>Year 3 (10/1/2013 – 9/30/2014) Year 4 (10/1/2014 – 9/30/2015) Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>services.</td>
<td></td>
<td></td>
<td>Metric 1 [I-11.1]: Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores. Demonstrate improvement over prior reporting period. Baseline/Goal: 2% improvement. Data Source: CG-CAHPS or other developed evidence-based satisfaction assessment tool, available in formats and language to meet patient population.</td>
</tr>
<tr>
<td>Metric 2 [I-11.2]: Percentage of patients receiving survey. Specifically, the percentage of patients that are provided the opportunity to respond to the survey. Demonstrate improvement over prior reporting period. Baseline/Goal: 5% improvement. Data Source: Performing provider documentation of survey distribution; EHR.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>020834001.1.4</td>
<td>1.1.2</td>
<td>1.1.2 A-C</td>
<td><strong>EXPAND EXISTING PRIMARY CARE CAPACITY: CONVENIENT CARE CENTERS</strong></td>
</tr>
<tr>
<td>--------------</td>
<td>------</td>
<td>---------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Memorial Hermann Hospital System</strong></td>
<td></td>
<td></td>
<td>020834001</td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s):</strong></td>
<td><strong>020834001.3.4</strong></td>
<td><strong>IT-1.10</strong></td>
</tr>
<tr>
<td><strong>Diabetes Care : HbA1c poor control (&lt;9.0%)-NQF 0059 Stand Alone Measure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>(10/1/2012 – 9/30/2013)</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>(10/1/2013 – 9/30/2014)</strong></td>
</tr>
<tr>
<td><strong>Year 4</strong></td>
<td><strong>(10/1/2014 – 9/30/2015)</strong></td>
<td><strong>Year 5</strong></td>
<td><strong>(10/1/2015 – 9/30/2016)</strong></td>
</tr>
<tr>
<td><strong>Milestone 10 [I-12]:</strong> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1 [I-12.1]:</strong> Documentation of increased number of visits. Demonstrate improvement over prior reporting period.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline/Goal: 5% increase over DY 2 baseline. (Approximately 11,900 visits)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Registry, EHR, claims, or other Performing Provider source.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $4,047,724</td>
<td>Year 3 Estimated Milestone Bundle Amount: $4,415,849</td>
<td>Year 4 Estimated Milestone Bundle Amount: $4,428,686</td>
<td>Year 5 Estimated Milestone Bundle Amount: $3,658,480</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $16,550,739</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Project Option 1.1.1 - 1.1 Expand Primary Care Capacity: Pediatric Clinic Expansion – Houston Northwest Pediatric Clinic

Unique Project ID: 020834001.1.5
Performing Provider Name/TPI: Memorial Hermann Hospital System/ 020834001

Project Summary:
Provider: Memorial Hermann Hospital System (Memorial) is a 1,164 bed hospital system consisting of 4 campuses in the Houston-Sugarland-Baytown MSA. The system serves a population of approximately 6,000,000 people.

Intervention(s): Memorial will establish the Houston Northwest Pediatric Clinic which will provide primary care for pediatric patients in that area of Harris County. Memorial will contract UTHSC-H to provide physician services to complement Memorial’s investment in new technology, equipment and space to better provide pediatric services.

Need for the project: Prospective pediatric patients in the targeted service area described below currently face many roadblocks to adequate primary care including economic burdens, language barriers and lack of knowledge for seeking pediatric care. Due to the shortage of primary care providers in the community, the average wait period for a primary care appointment is 17 days, which results in increased reliance on hospital EDs for primary care and non-emergent care. The project will increase the percentage of patients who receive appropriate primary care including preventative services and regular monitoring for patients with chronic illnesses.

Target population: The target population is children in the area of Harris County that is between Halls Bayou to the North, Beltway 8 to the West, I-10W and I-610NW to the South, and the Hardy Toll Road to the East. This area encompasses 14 census tracts with a total of over 15,000 children living below the federal poverty level, who are on Medicaid, or would be eligible for Medicaid. Furthermore, it is estimated that 39.8% of the patients in the service area for this clinic are either uninsured or underinsured children. Many of these children rely on Memorial Hermann’s and other hospitals’ emergency departments for primary care services.

Category 1 or 2 expected patient benefits: The clinic will provide a more appropriate setting for pediatric primary care for the target population. They will benefit primarily from better access to primary care and better management of illness and chronic conditions. The clinic is expected to be running at capacity (a conservatively estimated rate of approximately 15,000 patient visits per year) by July of DY4 and we expect to have provided a total of approximately 36,000 patient visits DY3-DY5. It is expected that 60% of these will be Medicaid/Medicaid-eligible patients (21,600).

Category 3 outcomes: IT-1.20 Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Standalone)—Increase the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months as measured by the Asthma Therapy Assessment Questionnaire (ATAQ).
Project Option 1.1.1- Establish More Primary Care Clinics: Pediatric Clinic Expansion -
Northwest Houston Pediatric Clinic

Unique RHP Project Identification Number: 020834001.1.5

Performing Provider Name/TPI: Memorial Hermann Hospital System/020834001

Project Description: 1.1/1.1.1: Using the strengths developed during their longstanding partnership, Memorial and The University of Texas Health Science Center at Houston (UTHSC-H) intend to work together to address the shortage of pediatric primary and specialty care in Region 3. In this project, Memorial will establish the Northwest Houston Pediatric Clinic, which will provide primary care for pediatric patients in an area of Harris County that is between Halls Bayou to the north, Beltway 8 to the west, I-10W and 610NW to the south, and the Hardy Toll Road to the east. Memorial has defined the service area for this clinic as a priority area for pediatric services, because it contains 14 of the 81 census tracts that make up the top 10% of all census tracts in Harris County with the greatest number of people below the age of 18 that are living below the federal poverty level (FPL). (The census tracts are 5333, 5331, 5321, 5320.01, 5307, 5223.01, 5221, 5214, 5206.02, 2217, 2216, 2215, 2214, and 2213.) The number of children living below the FPL in these 14 census tract areas is estimated to be approximately 15,415, who would either be on Medicaid, or are Medicaid-eligible. This clinic will market services to this population and provide services to those who respond. The capacity of the clinic is expected to be over 15,000 patient visits per year. Using a very conservative estimate of 50% of these clinic visits being with Medicaid/Medicaid-eligible patients, we would see a total of at least 7,500 Medicaid primary care visits per year. (UT Physicians’ current payer mix for pediatrics includes a 60% mix of Medicaid and non-resource.) We estimate that we will have provided 36,000 patient visits by the end of DY5, with approximately 21,600 of them being for patients on Medicaid, or who are Medicaid-eligible (using UT Physicians’ current rate of Medicaid/Medicaid-eligible pediatric patients). Furthermore, these areas have particularly high numbers of Hispanics (64.6%), for whom language, as well as poverty, may pose a barrier to obtaining primary care for their children. Black/African Americans, another segment of the population that tend to be medically underserved, also make up a significant proportion of the population in these census tracts (20.4%). The service area for this clinic includes large populations with economic, cultural, language, and transportation barriers to receiving primary care. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties.) In order to address the unique needs of different communities in the greater Houston area, Memorial has chosen to establish a pediatric clinic in this area as an independent DSRIP project.

Using their longstanding partnership to provide quality healthcare as a base, Memorial will contract UTHSC-H to provide physician services to complement Memorial’s investment in new technology, equipment and space to better provide pediatric services. Specifically, UTHSC-H
will redirect pediatricians already on its staff who have the capacity to care for additional patients, recruit additional pediatricians, or increase residency programs to fill the need for additional pediatric specialists. UTHSC-H is uniquely positioned to attract and retain new physicians due to its accomplishments as a world-class academic and research institution. This additional service line will avoid duplication and draw on the strength of UTHSC-H’s academic presence in the field of pediatric medicine, and will also benefit Memorial by increasing the quantity, quality, and scope of services provided at its facilities.

Practically, Memorial will subcontract with UTHSC-H to provide physician and other services needed to implement this project. For example, Memorial will lease additional space to open the North Harris County clinic. This space will include additional consulting, exam and procedure rooms. Memorial will also subcontract with UTHSC-H to provide primary care providers and support staff to operationalize the project. For all services in which UTHSC-H is a subcontractor, Memorial will pay an agreed rate that is set in advance and represents fair market value for services negotiated in the ordinary course of business through an arms-length transaction.

**Goal(s) and relationship to Regional goal(s):**

**Project goals:**

Expand the capacity of pediatric primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that pediatric patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.

This project meets the following Region 3 goals:

One of the goals of the region is to “Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay”. Expansion of primary care capacity certainly relates to this goal as it will make it easier for Memorial to provide care to underserved populations.

**Challenges and how addressed:**

This project faces three key challenges. First, Memorial must raise awareness and change existing patterns for seeking health care services for some patients. A second challenge is to raise awareness for the service delivery model offered by these new sites so that patients who currently don’t have access to after-hours care learn that this type of care is available through a physician’s clinic rather than turning to emergent or urgent care clinics. And finally, recruiting additional primary care providers and pediatric specialists in this competitive environment will be a challenge. Memorial will address these challenges by implementing other projects to reduce inappropriate ED use, educating patients on the benefits of primary care, and aggressively
recruiting primary care providers by offering competitive salaries and other incentives to practice in the outlying clinics.

5-year expected outcome for provider and patients:

There will be shortening of waiting times for primary pediatric care appointments and increased uptake of primary pediatric care services in this specific service area, which will increase the percentage of patients who receive appropriate primary health care, including preventative services and regular monitoring for those patients with chronic illnesses. In total, we expect to provide primary care visits totaling over 15,000 per year, once the clinic is running at capacity. Since this clinic will serve an area with a high rate of children living below poverty, we expect that at least 7,500 of these patient visits per year will be from the Medicaid/Medicaid-eligible population. We expect to have provided a total of approximately 36,000 patient visits DY3-DY5, with approximately 21,600 of them being Medicaid/Medicaid-eligible patients.

Starting Point/Baseline: Memorial has identified the targeted service area needing increased access to pediatric primary care. Since this will be a new clinic, the baseline will have to be established during DY3.

Rationale:

Reasons for selecting the project option: In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively (comparable ratios for US total are 219.5 and 90.5, respectively). From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Therefore, there is a significant need to expand primary care in order to facilitate delivery system reform.

Research has shown that access to primary care is associated with better health outcomes at less cost. Access to primary care ensures better preventive care and better management of chronic disease, with lack of access often resulting in more expensive care, received in hospitals and emergency departments (ED). For the fiscal year 2010, 10% of all potentially preventable hospitalizations (PPR) were ambulatory care sensitive. In 2009, 41% (390,945) of ED visits in Houston were primary care related (PCR), including non-urgent, primary care treatable, and primary care preventable, and for 26.8% (104,762) of these PCR visits, Medicaid was the payor. Getting more patients into primary care will help to reduce the use of this more costly care. Placing more primary care providers out in the communities will help to address transportation access barriers and the expansion of clinic service hours will provide a greater selection of available appointment times. By increasing primary care capacity, engaging more people in the
primary care system, and avoiding inappropriate utilization of costly services, the community will experience better health outcomes and greater patient satisfaction.¹

In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Because UTHSC-H will IGT on behalf of Memorial for its successful implementation of delivery system improvements under the Waiver, this structure results in a payment from a private hospital to an entity that provides its IGT, which arguably raises questions regarding provider donations. Nonetheless, this collaboration is the most to effective and efficient structure to expand access to pediatric services to the community, and ensure overall improvement to the Region 3 delivery system. This collaboration is a natural progression of the existing relationship and the clinical strengths of Memorial and UTHSC-H. Memorial is the largest not-for-profit healthcare system in Texas and serves the greater Houston community through 12 hospitals, a vast network of affiliated physicians and numerous specialty programs and services. With over 4,000 medical staff members, 26 residency programs, 48 fellowship programs, and over 1,300 physicians in training, Memorial is dedicated to providing high quality health services in order to improve the health of the people in Southeast Texas. The mission of UTHSC-H is to educate health science professionals, discover and translate advances in the biomedical and social sciences, and model the best practices in clinical care and public health. UTHSC-H strives to improve the health of the public in the State of Texas through educating future public health practitioners and bringing evidence based public health practices to Texas. UTHSC-H’s faculty of over 900 physicians in 80 specialties provide comprehensive care for patients while teaching 800 medical students and over 900 residents in over 60 accredited residency/fellowship programs.

Core Components:

Through the new Northwest Houston Pediatric Clinic, we propose to:

¹ PPR rate was from the Texas Health and Human Services Commission report on Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal year 2010, published January, 2012. The statistics for ED use were from the Houston Hospitals Emergency Department Use Study (January 1, 2009 through December 31, 2009), Final Report included in the 2010 Harris County Community Needs Assessment for Memorial Hermann.
a) Memorial will identify and lease appropriate space within the defined service area to establish the new clinic that includes reception, consulting, exam and procedure rooms, and will provide the necessary equipment and furnishings.

b) UT Physicians will be contracted at fair market value to provide primary care physicians, advanced practice providers, and support staff to operate the clinic.

c) In addition to regular business hours, the clinic will operate with expanded evening and Saturday hours to increase access for individuals that are not able to leave their jobs for healthcare appointments, and to provide care for those needing urgent care services that can be accommodated in a primary care clinic.

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

CN1 – Primary Care

CN8 – High rates of inappropriate emergency department utilization

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

This project represents a significant improvement in Memorial’s ability to deliver primary healthcare to babies, children, and adolescents. This new initiative proposes to add space, providers, support staff, and extended service hours in a location where economic and cultural barriers to receiving appropriate healthcare are indicative of a need for services that are conveniently located and available when needed. This project is an expansion of services in order to improve access to care.

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

**OD-1 Primary Care and Chronic Disease Management: IT-1.20 Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Non-Standalone)**

Increase the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months as measured by the Asthma Therapy Assessment Questionnaire (ATAQ).\(^2,3,4\) The ATAQ was found to have “good internal consistency and strong relationships with existing validated measures of childhood health status, asthma impact, and health care utilization.”\(^5\) The score range on the 7-item ATAQ is 0-7, with 0 showing complete control and each score of 1 thereafter indicating an area in need of improved

---


\(^5\) Ibid.
management. The ATAQ will be administered at each patient visit for patients with a diagnosis of asthma. Improvement is defined as a downward trend in the total score for the 7-items on the ATAQ for each individual patient.

OD-1 Primary Care and Chronic Disease Management: IT-1.1 Third next available appointment (Non-standalone measure)

Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

OD-9 Right Care, Right Setting: IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381273 (Standalone measure)

Numerator: Percentage of clinic patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period. Denominator: Denominator is all clinic patients age two through age 18, diagnosed with asthma during the measurement period. The denominator will include recipients with claims with asthma as primary or secondary diagnoses with the dates of service being within the measurement period.

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

Asthma is one of the most common chronic illnesses among children in the U.S.\(^6\) The National Health Interview Survey (2011) found that 14% of all children living in the U.S., 21% of non-Hispanic black children, and 18% of children in poor families had ever been diagnosed with asthma.\(^7\) The number of children residing in the defined service area for this clinic is estimated at over 31,000, with 20.4% of those being non-Hispanic black (over 6,324) and 49% living below the federal poverty level (over 15,000). (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties.) By extrapolating the U.S. statistics on children with asthma to the service area for this clinic, we can conservatively estimate that there are at least 4,340 children in this area suffering from asthma. Since the service area for this clinic has a high proportion of children living below the federal poverty level and a high proportion of non-Hispanic black children, achieving better asthma control for these patients will be an important and worthy outcome measure of increasing access to primary care services for children.


After the assessment of severity for the initial diagnosis, the goal then becomes asthma control, demonstrated through symptom manifestation and disease activity. The use of the ATAQ itself has benefits beyond simple measurement—it is a tool to ensure regular assessment and the consistent questioning can teach children and/or their parents which symptoms and experiences should be anticipated for managing their asthma.8

By increasing access to primary care and providing education and support in gaining control over asthma, the project has the potential to prevent the acute worsening of the illnesses, thereby decreasing the need for emergency care. Hence ED visits for asthma will be a good outcome measure for this project. Finally, patients are more likely to arrive for their appointments when they are able to get them when needed and when most convenient. Consequently, we will be measuring third next available appointment as a measure of increased access to primary care services.

**Relationship to Other Projects:** This project is part of Memorial’s larger plans to expand and develop primary care and specialty care services, while improving access to care. Expanding primary care supports/reinforces several of the Category 1 and 2 projects: increasing the number of physicians rotating through the primary care residency program will have a direct impact on Expanding Primary Care Capacity (1.2); this project not only will increase the number of available physicians to participate in medical homes (2.1), it will also ensure that they are trained in the medical home concept; this project reinforces the Redesign of Primary Care (2.3), the Redesign to Improve the Patient Experience (2.4).

**Relationship to Other Performing Providers’ Projects in the RHP:** Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

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

**Project Valuation:** The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of

---

people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

The expansion of primary care clinics will help address a substantial need in the community for increased access to primary care. It will also go a long way towards achieving the Waiver goal of improving outcomes while curbing the risk of healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes.
### Related Category 3

**Outcome Measure(s):**
- 020834001.3.6
  - IT-1.20
- 020834001.3.5
  - IT-1.1
- 020834001.3.7
  - IT-9.3

### Related Category 4

**Outcome Measure(s):**
- Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Standalone)
- Third next available appointment (Non-standalone measure)
- Pediatric/Young Adult Asthma Emergency Department Visits - NQF 1381273 (Standalone measure)

### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1 [P-X1]:** Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign

**Metric 1 [P-X1.1]:** Documentation of plan for the new clinic.
- Goal: Implementation plan (eligibility criteria, implementation components, responsibilities, and timeline).
- Data Source: UT Physicians’ documents.

**Milestone 1 Estimated incentive payment:** $2,238,923

**Milestone 2 [P-X2]:** Designate/hire personnel or teams to support and/or manage the project/intervention

**Metric 1 [P-X2.1]:** Project managers, personnel assigned to teams, and team

### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 3 [P-1]:** Establish an additional primary care clinic

**Metric 1 [P-1.1]:** Number of additional clinics.
- Goal: 1 new clinic
- Data Source: New primary care schedule and other UT Physicians' documents.

**Milestone 3 Estimated incentive payment:** $1,628,853

**Milestone 4 [P-5]:** Hire additional primary care providers and staff

**Metric 1 [P-5.1]:** Documentation of increased number of providers and staff.
- Goal: 2 FTE Pediatricians, 3 FTE Nurse Practitioners, 6 Support staff
- Data Source: UT Physicians' report, policy, contract or other documentation

### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 5 [P-X5]:** Expand the hours of a primary care clinic, including evening and/or weekend hours

**Metric 1 [P-X5.1]:** Increased number of hours at primary care clinic over baseline.
- Goal: 6 evening hours, 4 weekend hours
- Data Source: Clinic documentation

**Milestone 5 Estimated incentive payment:** $2,457,371

### Year 5 (10/1/2015 – 9/30/2016)

**Milestone 6 [P-4]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 [P-4.1]:** Documentation of increased number of visits.
- Goal: Increase of 5,231 over previous reporting period for a total of 13,487
- Data Source: Registry, EHR, claims or other UT Physicians’ source

**Milestone 6 Estimated incentive payment:** $2,050,788

**Milestone 7 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 [I-12.1]:** Documentation of increased number of visits.
- Goal: Increase of 769 over previous reporting period for a total of 14,256 for the reporting period
- Data Source: Registry, EHR, claims or other UT Physicians’ source

**Milestone 7 Estimated incentive payment:** $2,050,788

**Milestone 8 [I-11]:** Patient satisfaction with primary care services.

**Metric 1 [I-11.1]:** Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores.
- Goal: Demonstrate improvement over prior reporting period.

**Milestone 8 Estimated incentive payment:** $2,050,788

**Milestone 9 [I-11]:** Patient satisfaction with primary care services.

**Metric 1 [I-11.1]:** Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores.
- Goal: Demonstrate improvement over prior reporting period.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>PEDIATRIC CLINIC EXPANSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>020834001.3.6</td>
<td>IT-1.20IT-1.1</td>
<td>Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Standalone)</td>
</tr>
<tr>
<td>02084001.3.5</td>
<td>IT-9.3</td>
<td>Third next available appointment (Non-standalone measure)</td>
</tr>
<tr>
<td>020834001.3.7</td>
<td></td>
<td>Pediatric/Young Adult Asthma Emergency Department Visits- NQF 1381273 (Standalone measure)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal: 1 project manager, 3 support personnel</td>
<td>Milestone 4 Estimated incentive payment: $ 1,628,852</td>
<td>for the reporting period Data Source: Registry, EHR, claims or other UT Physicians' source</td>
<td>Goal: A statistically significant increase at the 95% level in both the overall mean score for patient satisfaction and in the score for ability to get appointment when wanted. Data Source: CG-CAHPS survey results (Press-Ganey)</td>
</tr>
<tr>
<td>Data Source: Program Documentation</td>
<td><strong>Milestone 5 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.</strong></td>
<td>Milestone 7 Estimated incentive payment: $ 2,457,370</td>
<td>Milestone 9 Estimated incentive payment: $2,050,787</td>
</tr>
<tr>
<td>Milestone 2 Estimated incentive payment: $ 2,238,923</td>
<td><strong>Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.</strong> Baseline: 0 (New Clinic) Goal: 8,256 Data Source: Registry, EHR, claims or other UT Physicians' source</td>
<td><strong>Year 2 Estimated Milestone Bundle Amount: $ 4,477,846</strong></td>
<td><strong>Year 3 Estimated Milestone Bundle Amount: $ 4,886,557</strong></td>
</tr>
<tr>
<td><strong>Year 3 Estimated Milestone Bundle Amount: $ 4,914,741</strong></td>
<td><strong>Year 4 Estimated Milestone Bundle Amount: $ 4,101,575</strong></td>
<td><strong>Year 5 Estimated Milestone Bundle Amount: $ 4,101,575</strong></td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 18,380,719</strong></td>
</tr>
</tbody>
</table>
Memorial Medical Center
Pass 1
Project Option 1.1.4- “Other”: Hospital based clinic-access to primary/specialty care

Unique RHP Project ID: 137909111.1.1/Pass 1

Performing Provider Name/TPI: Memorial Medical Center / 137909111

Project Summary:

Provider:
Memorial Medical Center is a county-owned, 25 bed Critical Access Hospital and serves as the only hospital for Calhoun County. Located on the Gulf Coast, Memorial Medical Center serves 60% of the 21,382 County residents. With a tax base of $13,972,000, Memorial Medical Center was able to provide more than $8 million in charity care (includes uncompensated) during FY 2012.

Volume Statistics – 11 months

<table>
<thead>
<tr>
<th>Year to date 2011 - 2012</th>
<th>Patient Payer Mix</th>
<th>Patient/Community Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions- 1056</td>
<td>Medicaid and CHIP- 16.4%</td>
<td>Hispanic- 47.1%</td>
</tr>
<tr>
<td>Births (babies delivered)- 98</td>
<td>Medicare- 33.6%</td>
<td>African American- 3.3%</td>
</tr>
<tr>
<td>Emergency visits- 9084</td>
<td>Commercial Insurance- 31.1%</td>
<td>Caucasian- 44.4%</td>
</tr>
<tr>
<td>Outpatient visits- 13,430</td>
<td>Uninsured, Charity, Indigent Care- 18.9%</td>
<td>Asian- 4.5%</td>
</tr>
<tr>
<td>Laboratory procedures- 224,562</td>
<td></td>
<td>American Indian- 0.7%</td>
</tr>
</tbody>
</table>

Intervention(s):
This project will expand primary and specialty care services through a hospital-based clinic to a medically underserved area of rural Texas.

Need for the project:
The purpose is to provide access to both primary and specialty care services in an area where two-thirds of the population travels outside the service area for health care. Patients requiring specialty care must often drive long distances to see a provider, and may not receive services until the condition becomes critical. Patients needing primary care are unable to get appointments, delay care until it is more critical, and use the emergency room department for care that could have been provided in a physician’s office.

Target Population:
All patients within the system with may benefit from this project (Medicaid and CHIP-16.4% / Medicare- 33.6%), specifically those with chronic diseases.

Category 1 or 2 expected patient benefits:
Over the course of this project, we will increase the total number of encounters for both primary care and specialty care services by 15% each by the end of DY 5. By doing so, we will improve the health of our clients by providing more timely access to care and coordinating treatment and follow-up care that isn’t available when patients seek treatment through the Emergency Department.

Category 3 outcomes:
OD-6 & OD-9: Because the community we serve has an insufficient number of providers and patients are often unable to obtain appointments in a timely manner, the priority goal for this project is ensuring patients receive care when they need it and without significant delays, which will result in improved health outcomes and patient satisfaction. With access to care locally, we anticipate a subsequent cost savings due to the decreased inappropriate utilization of the Emergency Department. In DY5, patient experience at the Hospital Based Clinic shall have
improved in deficient areas of timely care, appointments and information by 10% by the end of the waiver.
Project Options 1.1.9 4– Other project option: Hospital based clinic improving access to primary and specialty care

Unique RHP Project Identification Number: 137909111.1.1
Performing Provider Name/TPI: Memorial Medical Center / 137909111

Project Description:
To increase the ability of Memorial Medical Center (MMC) to provide the “right care at the right time in the right setting,” this project will expand access to primary and specialty care services through the establishment of a hospital-based clinic.

This initiative will provide critically needed services to a medically underserved area of rural Texas as identified in our Region’s community needs assessment. To ensure patients have access to services at times that are convenient for them, are able to secure appointments with appropriate providers, and to reduce the inappropriate use of the hospital emergency department for non-urgent and primary care services, the clinic will offer extended and non-traditional hours of care.

Currently, the Region faces challenges providing both primary care and specialty care services to the community population. Every county in the region, including Calhoun County (the home of MMC) faces shortages of primary care, behavioral health care, and other specialty care providers, causing delays in care until medical care becomes an urgent need. Patients requiring specialty care must often drive long distances to see a provider, and may not receive services until the condition becomes critical. Patients needing primary care are unable to get appointments, delay care until it is more critical, and use the emergency room department for care that could have been provided in a physician’s office. This creates unnecessary costs and burdens on the existing health care system, and may contribute to less healthy outcomes in patients. Attracting additional providers to the area is a challenge given the lack of clinical space, or access to specialty providers to whom they may refer their patients.

Goals and Relationship to Regional Goals:
Through the creation and operation of a hospital-based clinic and hiring of primary and specialty care providers, this project will enable MMC to better meet the community and Region needs for health care services. The goals of this project are:

- Improve access to primary care providers and services;
- Improve access to specialty care providers and services;
- Reduce the need for clients to travel excessive distances for health care services;
- Increase the number of health care providers and services available to community residents;
- Reduce the inappropriate use of emergency rooms for non-urgent care;
- Provide access to care during non-traditional hours for patients who work, care for children, do not have transportation, or face other challenges that make it difficult for them to seek care during typical business hours;
- Improve health care outcomes by providing health care services that might not otherwise be available to residents and enabling patients to obtain more timely care before conditions become more serious and costly to treat;
- Reduce hospital readmissions by providing care coordination and patient follow-up when discharged from the hospital;
• Improve patient satisfaction by providing care in a more appropriate setting and reducing the wait time that typically accompanies visits to the emergency department.

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

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

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

• Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and

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

5-Year Expected Outcome for Provider and Patients:
Over the course of this project, we will establish a clinic that will provide both primary and specialty care services, and gradually increase the number of primary care and specialty care encounters so that the total number of encounters for both primary care and specialty services increase by 15% each by the end of Demonstration Year (DY) 5. By doing so, we will improve the health of our clients by providing more timely access to care and coordinating treatment and follow-up care that is not available when patients seek treatment through the emergency department. We also will improve patient satisfaction as patients will have a regular source for care that is less costly, more efficient, and better meets their health care needs. The project supports the Region’s goals of ensuring residents have timely access to necessary health care services from an appropriate setting, within a reasonable distance, and receive the most cost-effective and appropriate treatment that enhances their ability to live healthy, productive lives.

Starting Point/Baseline:
No space currently exists for primary or specialty care providers. Therefore, the baseline for the number of patients and the number of clinics and participating providers begins at 0 in DY 2.

Rationale:
Memorial Medical Center (MMC) is located in Port Lavaca, Texas, which is located on the Gulf of Mexico between Corpus Christi and Houston. The city is in Calhoun County. Port Lavaca’s population is approximately 11,500 and includes about 60% of the 21,381 county residents.1 Memorial Medical Center is a county-owned, 25 bed Critical Access Hospital and serves as the only hospital for Calhoun County. Port Lavaca Clinic and Coastal Medical Clinic serve as the primary providers for outpatient services.

Like other counties in our Region, Calhoun County is a designated Medically Underserved Area for Primary Care, Mental Health Care, and Dental Care.2 Due to further

---

1Texas State Data Center, Texas Population 2010.
shortage of providers, an application was submitted in September 2012 for designation as a Health Professional Shortage Area. The most recent data from the Texas Medical Board shows Calhoun County has a total of 18 physicians, including seven in General Practice or Family Medicine, one Pediatrician, five who practice Internal Medicine, and two OB/GYNs. However, since the study, five physicians have left the service area due to retirement, relocation and/or contract elimination.

MMC’s primary service area is almost exclusive to the Port Lavaca zip code. The secondary service area includes the remainder of Calhoun County and the southwestern portion of adjacent Matagorda County. To better understand the community’s needs and determine the steps MMC needs to take to adequately serve the region’s patients, in 2010 MMC contracted with BR Healthcare Services, Inc. (BRHS) to conduct an analysis of MMC’s current market, the primary and secondary service area, demographics, and outmigration. The study found that 73% of patients served by MMC lived in the Port Lavaca zip code area, while 18% of patients lived in Calhoun County and Palacios. During the time period of the study, the patient population included 33.6% who are covered by Medicare; 16.4% who are covered by Medicaid; 31.1% who are insured by a commercial plan; and 18.9% who are uninsured, charity and indigent care patients.

At the time of the study, the MMC medical staff included 13 physicians. Twelve hold active statuses and one is Sr. Active. Another 26 providers are “courtesy” or “consulting” staff. Of the 13 Active Staff physicians in 2010, all provided direct patient care or have full time offices in the area. The average age is 48 years. One Active Staff physician is over 60 years and is listed as Sr. Active. Approximately 70% of the MMC physicians are concentrated in the age 45-60 range.

Using these current physician supply information and other data, the BRHS study conducted a Physician Needs Assessment utilizing four separate mathematical methodologies. Three indexed physician demand for services and the fourth utilized National supply numbers. In assessing the physician supply needs for the community, the BRHS analysis reviewed various data and considered both current and future population needs. The results of the analysis concluded that community need currently exists for additional physicians in the following areas of care: 1) Family Practice; 2) Internal Medicine; 3) Pediatrics; 4) Cardiology (Non-invasive); 5) General Surgery; 6) Obstetrics/Gynecology; and 7) Orthopedic Surgery.

Due to various methodologies and data resources used in each of the studies, the range of providers needed varied, and is demonstrated in the following table.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Current Number</th>
<th>GMENAC</th>
<th>Hicks &amp; Glenn</th>
<th>Group Health</th>
<th>AMA</th>
<th>Need Avg.</th>
<th>Additional Physicians Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practice</td>
<td>6</td>
<td>7.04</td>
<td>6.93</td>
<td>8.72</td>
<td>5.7</td>
<td>7.1</td>
<td>1.1</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>4</td>
<td>5.94</td>
<td>3.63</td>
<td>4.1</td>
<td>8.78</td>
<td>5.6</td>
<td>1.6</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>1</td>
<td>3.08</td>
<td>2.65</td>
<td>3.18</td>
<td>3.74</td>
<td>3.2</td>
<td>2.2</td>
</tr>
<tr>
<td>Cardiology</td>
<td>0</td>
<td>0.65</td>
<td>0.79</td>
<td>1.02</td>
<td>1.38</td>
<td>1.0</td>
<td>1.0</td>
</tr>
</tbody>
</table>

---

3 Texas Medical Board, Physician Demographics by County and Specialty, January 2012. Note: the remaining 2 physician specialties are not noted in the Texas Medical Board data; Further, five physicians left service area since publication.
5 Since the time of the study, two primary care physicians have left the service area.
6 BR Healthcare Services, Inc., 2010.
7 The physician demand was calculated based on the following studies: GMENAC, Hicks & Glenn, Group Health and U.S. Supply, AMA Physician Characteristics and Distribution in the U.S.
Further, the Community Needs Assessment conducted identified that 70% of Calhoun County (14,968) outmigrated for healthcare services due to physician shortages. When travel wasn’t possible for the patient, we found inappropriate use of the Emergency Department for healthcare needs/services.

This project will target all residents of Calhoun County. Approximately 50% of patients are either Medicaid eligible or indigent/uncompensated, so we expect they will benefit from the services provided. Additionally, annual emergency room visits are approximately 11,000 with Medicaid and indigent patients representing 54% of visits. Over the course of the project, the total patient impact is expected to be approximately 3500 patients (DY 2: establish baseline, DY 3: 800 patients impacted, DY 4: 1,000 total patients impacted and DY 5: 1,700 total patients impacted). In addition, the project will develop and implement an evidence based patient satisfaction survey tool with an average of 2,000 patients expected to be surveyed each year.

**Project Components:**

Through the establishment of a new clinic, we propose to meet all required core project components of 1.1.2 as described below. Project option 1.1.94 does not have any core components. However, this project will meet the primary objectives, which is to establish more primary care clinics and improve access to specialty care. For Project 1.1.2, We will meet all three components: a) Expand primary care clinic space; b) expand primary care clinic hours; and c) expand primary care clinic staffing.

Our clinic will provide both primary care and specialty care providers based on the needs identified for our community. The clinic will a) provide additional clinic space for primary care providers and patients; b) provide expanded clinic hours to ensure patients have access to care that fits within their schedule; and c) provide clinic staffing, including both providers and necessary administrative staff.

The operation of a hospital-based primary and specialty care clinic significantly enhances our existing delivery system by allowing us to meet a critical community need. Because these services will be provided by a clinic affiliated with the hospital, we also will be able to coordinate services provided to patients discharged from the hospital, improve our ability to ensure compliance with out-patient care instructions, and reduce readmissions. Studies have shown that integrating hospital and outpatient care is key to reducing readmissions and that strong relationships between hospitals and primary care providers improve patient outcomes.8

While we recognize this is an ambitious project, it is an important initiative that will significantly improve access to care for the patients in this Region MMC currently is unable to provide these critical services and has long recognized the need for a clinic. By creating a hospital-based clinic, patients will have access to a full-range of services not available in a stand-alone facility. Our plans will build on our existing experience in delivering high-quality health care, and will leverage the existing infrastructure and administrative services provided by MMC to provide a full-service clinic.

**Unique community need for identification numbers the project addresses:**

- CN.1 – Inadequate access to primary care
- CN.2 – Inadequate access to specialty care

---

**Challenges:**
MMC has identified several challenges in developing this initiative, but is prepared to fully address each one of these in our implementation plan. One of the key challenges we face is attracting physicians to the clinic. To address this, our plan will include an outreach and marketing strategy to reach interested providers. Based on recommendations from BRHS, our expenditures in this area will be strategically prioritized to initially focus on the most critical physician needs. We will work with the local and state medical societies to publicize the new positions, as well as work with our Regional partners to identify potential candidates.

Another challenge will be educating clients to ensure they are aware of and utilize the new services. We will develop an education and outreach plan for the community, and will coordinate with local area providers to be sure residents are aware of the availability of the clinic. We will emphasize the availability of extended hours and will coordinate outreach with our emergency department and MMC administrative offices to inform and direct patients to the clinic when appropriate.

The population we serve also struggles with multiple chronic illnesses, including diabetes, chronic heart disease, COPD, and asthma, and has a high occurrence of behavioral health issues. The creation of a new clinic will provide many of these underserved patients with access to care in a more timely manner, and will provide them with a local, accessible medical home. Studies have shown that obtaining primary care through a medical home reduces the number of hospital admissions, provides lower outpatient costs, reduces pharmaceutical costs, and improves health care outcomes. To address the challenges of treating a wide range of medical problems and minimize potential complications, we will implement a process for ensuring our primary and specialty care providers work together to provide a coordinated approach to patient care. Clinic staff will also work closely with hospital staff to coordinate patient discharge planning and after-care, resulting in a reduction in hospital readmissions. For services that may not be available from our specialists, we will utilize existing partnerships and develop new ones with providers in other counties for patient referrals.

We also know that the population we serve includes a large number of industrial shift workers, many of whom work non-traditional schedules that prevents them from obtaining care during normal clinic hours. This project will enable us to better serve this particular population by providing appointments during the extended hours. We will continually monitor the adequacy of those hours through patient surveys. If the client responses indicate changes are needed in clinic hours, we will reassess our options and, to the extent possible, adjust hours as necessary.

**New Initiative for Provider:**
MMC currently operates a hospital that provides acute care, but does not provide access to primary and specialty care services. The operation of a hospital-based primary and specialty care clinic significantly enhances our existing delivery system by allowing us to meet a critical community need for care. Because these services will be provided by a clinic affiliated with the hospital, we will be able to coordinate services provided to patients discharged from the hospital, improve our ability to ensure compliance with out-patient care instructions, and reduce readmissions.

---

9 County Health Rankings and Roadmaps, County Health Rankings 2012.
11 Silow-Carrol, et.al.
**Related Category 3 Outcome Measure(s):**

OD-6 Patient Satisfaction is the selected Category 3 Outcome Measure for this project. We intend to use the CG-CAHPS survey to improve our performance as measured by whether patients are (1) getting timely care, appointments and information. Obtaining patient feedback on our ability to provide the right care at the right time is critical to the success of this project and the internal operations of the clinic. This data will provide us with meaningful and objective information that will be used to determine whether our clinic has met patient expectations related to obtaining timely care and information, and will identify areas where we need to improve.

Because the community we serve has an insufficient number of providers and patients are often unable to obtain appointments in a timely manner, the priority goal for this project is ensuring patients receive care when they need it and without significant delays, which will result in improved health outcomes and patient satisfaction. The CG-CAHPS survey is an effective tool for measuring our progress and will provide valuable information and feedback on our performance and areas where improvement is needed.

In addition, OD-9 Right Care, Right Setting: With expansion of primary and specialty care access for patient care, MMC will be able to have an impact on decreasing our ER over-use. For non-emergent needs, we will direct patients to the extended hours clinic. This commitment will directly connect to IT-9.2 ED appropriate utilization which will:

1) Reduce all ED visits (including ACSC).

**Plan for Learning Collaborative:**

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. The learning collaborative meets our quality improvement milestone [P-1.1 and P-1.2].

**Relationship to other Projects and other Performing Provider’s Projects:**

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

This project will support and coordinate with other projects designed to improve access to primary and specialty care (Projects 1.1 and 1.9), enhance service availability (1.12), redesign to improve patient experience (2.4), and enhance medical homes (2.1). Our participation in the Learning Collaborative will allow us to share information and promote the use of best practices.

**Project Valuation:**

When determining a value for expanding access to primary and specialty care through a hospital based clinic in Calhoun County, we first determined the priority of this initiative to our community. Utilizing the Office of Extramural Research, National Institute of Health model, we identified the impact of this project as a high level. The insufficient access to these services in
our area, results in patients’ inability to locate a medical home; delayed diagnoses and treatment which leads to more serious health care conditions and higher costs; inappropriate utilization of emergency room facilities and higher costs; lack of care coordination and patient education. Further, in a 2010 BR Healthcare Services conducted a Market and Service Area Analysis that identified over 60% of Calhoun County residents sought medical treatment outside of the county. By providing access to care locally, an undue tax burden shall be offset reducing costs to local businesses and industry. Lower tax rates lend to business recruitment and workforce development adding to quality of life. Finally, we calculated the tangible expenses of space, utilities, technology, supplies, equipment, physician recruitment and staffing to determine the total project value. Living in rural Texas, we are painfully aware of the challenges to attract physicians to our area. Therefore, recruitment and salary packages must be competitive and access to health care resources plentiful to grow programs and patient satisfaction.
## Hospital Based Clinic Improving Access to Primary & Specialty Care

**Memorial Medical Center**

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th><strong>Hospital Based Clinic Improving Access to Primary &amp; Specialty Care</strong></th>
<th>137909111</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.4</td>
<td>3.1T-6.1</td>
<td>Patient Satisfaction</td>
<td>137909111</td>
</tr>
<tr>
<td>1.1.4</td>
<td>3.1T-9.2</td>
<td>Right Care, Right Setting</td>
<td>137909111</td>
</tr>
</tbody>
</table>

**Year 2 (10/1/2012 – 9/30/2013)**

**Milestone 1** [P-1]: Establish additional/expand existing/relocate primary care clinic

**Metric 1** [P-1.1]: Number of additional clinics or expanded hours or space on existing space

- **Baseline:** No space currently exists for primary care clinic/Goal: Establish space for two primary care providers.
- **Data Source:** Documentation of detailed expansion plans

**Milestone 1 Estimated Incentive Payment (maximum amount):** $188,152

**Year 3 (10/1/2013 – 9/30/2014)**

**Milestone 2** [P-X1]: Launch/expand a specialty clinic

**Metric 1** [P-X1.1]: Establish/expand specialty care clinic

- **Baseline:** No space currently exists for specialty care provider clinic/Goal: Establish space for two specialty care providers and services
- **Data Source:** Documentation of detailed expansion plans for specialty provider clinic space

**Year 4 (10/1/2014 – 9/30/2015)**

**Milestone 3** [I-X1]: Increase number of specialist providers available for the high impact/most impacted medical specialties

**Metric 1** [I-X1.1]: Increase number of specialist providers in targeted specialties over baseline

- **Goal:** Recruit and hire General Surgeon and develop office staff
- **Data Source:** HR documents or other documentation demonstrating employed/contracted specialists

**Milestone 3 Estimated Incentive Payment (maximum amount):** $185,261

**Year 5 (10/1/2015 – 9/30/2016)**

**Milestone 4** [I-X2]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1** [I-X2.1]: Documentation of increased number of visits

- **Goal:** Increase number of specialty visits by 15% over baseline in DY3
- **Data Source:** Registry, EHR, claims or other provider source

**Milestone 4 Estimated Incentive Payment (maximum amount):** $188,789

**Milestone 5** [I-X1]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1** [I-X1.1]: Documentation of increased number of visits

- **Goal:** Increase number of visits by 10% over baseline.
- **Data Source:** Registry, EHR, claims or other Performing Regional Healthcare Partnership Plan

**Milestone 5 Estimated Incentive Payment (maximum amount):** $185,261

**Milestone 6** [I-X2]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1** [I-X2.1]: Documentation of increased number of visits

- **Goal:** Increase visits 10% over baseline.
- **Data Source:** Registry, EHR, claims or other Performing Regional Healthcare Partnership Plan

**Milestone 6 Estimated Incentive Payment (maximum amount):** $188,789
### Hospital Based Clinic Improving Access to Primary & Specialty Care

**Memorial Medical Center**

| Related Category 3 | Outcome Measure(s): | 137909111.3.1 | 3.IT-6.1 | 137909111.3.5 | 3.IT-9.2 | 137909111.1.3.1 | Patient Satisfaction | Right Care, Right Setting | Year 2 (10/1/2012 – 9/30/2013) | Year 3 (10/1/2013 – 9/30/2014) | Year 4 (10/1/2014 – 9/30/2015) | Year 5 (10/1/2015 – 9/30/2016) |
|--------------------|----------------------|----------------|--------|................|--------|................|----------------------|-------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| Milestone 2        | Estimated Incentive Payment (maximum amount): | $188,153 | Milestone 5 | Estimated Incentive Payment: | $163,570 | Milestone 9 | Estimated Incentive Payment: | $165,261 | Milestone 13 | Estimated Incentive Payment: | $188,790 | Milestone 14 | [P-X]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. |
|                     |                      |                | Milestone 6 | [P-4]: Expand the hours of primary care clinic, including evening and/or weekend hours | Metric 1 P-4.1: Increased number of hours at primary and specialty clinic over baseline | Baseline: Clinic currently is not operational/Goal: Establish baseline hours of operation | Data Source: Clinic | Documentation of clinical hours. | Milestone 10 Estimated Incentive Payment: | $165,261 | Milestone 14 | [P-X]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. |
|                     |                      |                | Milestone 7 | [P-1.1]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. | Metric 1 P-1.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in. | Milestone 11 | Estimated Incentive Payment: | $165,261 | Milestone 14 | Estimated Incentive | |
|                     |                      |                | Milestone 8 | [I-X2]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. | Metric 1[I-X2.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. | Baseline: No specialty care patients are currently seen. Goal: 20 specialty care visits per week. | Data Source: Registry, EHR, claims or other Performing Provider sources. | Milestone 12 Estimated Incentive Payment: | $165,261 | Milestone 14 | Estimated Incentive | |
|                     |                      |                | Milestone 9 | [I-X2]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. | Metric 1[I-X2.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. | Baseline: No specialty care patients are currently seen. Goal: 20 specialty care visits per week. | Data Source: Registry, EHR, claims or other Performing Provider sources. | Milestone 13 Estimated Incentive Payment: | $188,790 | Milestone 14 | Estimated Incentive | |
|                     |                      |                | Milestone 10 | [I-X2]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. | Metric 1[I-X2.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. | Baseline: No specialty care patients are currently seen. Goal: 20 specialty care visits per week. | Data Source: Registry, EHR, claims or other Performing Provider sources. | Milestone 14 Estimated Incentive Payment: | $188,790 | Milestone 14 | Estimated Incentive | |
|                     |                      |                | Milestone 11 | [P-1.1]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. | Metric 1 P-1.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in. | Milestone 12 | Estimated Incentive Payment: | $165,261 | Milestone 14 | Estimated Incentive | |
|                     |                      |                | Milestone 12 | [P-X]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. | Metric 1 P-X.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in. | Milestone 13 | Estimated Incentive Payment: | $188,790 | Milestone 14 | Estimated Incentive | |

**Data Source:** Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.

**Metric 2 P-X.2:** Share challenges and solutions successfully during this bi-weekly interaction. Data Source: Documentation of interactions.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$188,153</td>
<td>$165,571</td>
<td>$165,260</td>
<td>$165,790</td>
</tr>
</tbody>
</table>

Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.

Metric 2 P-1.2: Share challenges and solutions successfully during this bi-weekly interaction.

Data Source: Documentation of interactions

Milestone 7 Estimated Incentive Payment: $163,571

Milestone 11 Estimated Incentive Payment (maximum amount): $165,260

Payment (maximum amount): $188,790

Year 2 Estimated Milestone Bundle Amount: $564,458

Year 3 Estimated Milestone Bundle Amount: $654,281

Year 4 Estimated Milestone Bundle Amount: $661,043

Year 5 Estimated Milestone Bundle Amount: $566,368

**Total Estimated Incentive Payments for 4-Year Period** (add milestone bundle amounts over Years 2-5): $2,446,150
Mental Health and Mental Retardation Authority of Harris County
Pass 1
1.12 Enhance service availability of appropriate level of behavioral health care: Expansion of outpatient behavioral health services for adults with severe psychiatric conditions (Northwest)

RHP Project Number: 113180703.1.1

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to increase outpatient capacity to potentially eliminate the current wait list for services in this geographic area.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. In an effort to provide needed services to the most critically ill population, MHMRA proposes to increase outpatient capacity by approximately 500 individuals potentially eliminating the current wait list for services in this geographic area. In order to address this issue we will choose to focus on project option 1.12.2: Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

It is important to note that we are proposing four similar projects, each under the 1.12.2 umbrella, which would expand outpatient behavioral health services for adults in each of our existing clinics. Outpatient services for this program include psychopharmacological interventions, provision of psychiatric medications to the medically uninsured, case management, psychosocial skills training and psychotherapy, family therapy and linkages to needed resources in the community. Each of the expansion program serves unique geographical needs, and therefore, each of the projects are critical to addressing the community needs.

MHMRA of Harris County provides adult mental health outpatient services to patients with serious mental illness according to a utilization management scheme intended to provide the right level of service matching the assessed severity of need. The majority of patients (78%) receive Level One service. This mix of assessment, case management and psychiatric treatment averages 13.44 hours per patient per year. At Medicaid reimbursement rates, these services would be valued at $1,209 per patient per year. In addition, MHMRA provides medications to the medically indigent at a rate of $2036 per person per year. The combined value of staff services and medications is estimated at $3,255 per person per year for this (lowest) utilization management group. The Level Two package adds cognitive behavior therapy for major depression to the service mix. Although the package averages nearly three times the service hours per person, the reimbursement rate is just slightly higher. Level Threes services include...
psychosocial skills training, doubling the hours of service over package Two, at a rate of $4,317 per person per year. Finally, Assertive Community Treatment (ACT) is the most intense and expensive package reserved for those most in need at an estimated cost/value of $6,975 per person.

<table>
<thead>
<tr>
<th></th>
<th>Proportion of Patients</th>
<th>Annual # Services per Patient</th>
<th>Annual Hours of Service per Patient</th>
<th>Annual Value of Services*</th>
<th>Annual Value of Medications</th>
<th>Total Cost/Value of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level One</td>
<td>78%</td>
<td>39.08</td>
<td>13.44</td>
<td>$1,219</td>
<td>$2,036</td>
<td>$3,255</td>
</tr>
<tr>
<td>Level Two</td>
<td>9%</td>
<td>63.23</td>
<td>34.5</td>
<td>$1,244</td>
<td>$2,036</td>
<td>$3,280</td>
</tr>
<tr>
<td>Level Three</td>
<td>10%</td>
<td>131.28</td>
<td>68.05</td>
<td>$2,281</td>
<td>$2,036</td>
<td>$4,317</td>
</tr>
<tr>
<td>ACT</td>
<td>1%</td>
<td>387.53</td>
<td>187.86</td>
<td>$4,939</td>
<td>$2,036</td>
<td>$6,975</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>59.12</strong></td>
<td><strong>25.26</strong></td>
<td><strong>1,428</strong></td>
<td><strong>$2,036</strong></td>
<td></td>
<td><strong>$3,464</strong></td>
</tr>
</tbody>
</table>

*2012 Medicaid Reimbursement Rates

Starting Point/Baseline:
As mentioned previously, 8,800 consumers are served among the four existing outpatient clinics. By adding the five teams proposed under the five related projects, the total adult outpatient capacity would be expanded to 11,300 treatment slots. The current project will add 500 of the expansion slots by DY4 and continuing through DY5. Current clinical space will be used in addition to redesigning available MHMRA space or seeking additional space as needed to house additional staff over the DSRIP period.

Rationale:
The community mental health system in Harris County has a limited capacity for service that is insufficient to the needs of its residents. The Mental Health Needs Council of Harris County has estimated that 153,000 of the 552,000 Harris County adults with mental illness have a severe mental illness (Depression, Bipolar Disorder, and Schizophrenia). These individuals are among the 96,200 Harris County adults who have no public (Medicaid or Medicare) or private health insurance and therefore, are totally dependent on the public mental health service system for treatment. In 2007, approximately 27,000 adults received services from the public mental health system; 18,200 of these were uninsured (a number representing only 19% of estimated need). By deduction, one can conclude that approximately 78,000 adults with severe mental illness failed to access treatment from the public or private mental health systems.

The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the waiting list for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service.

On August 31 (2012), the MHMRA waitlist for adult mental health outpatient services rested at 1,695, a level that has persisted for several years. Further, tenure on the waiting list approached five months, an average of 149.16 days. The majority of consumers on the MHMRA waitlist (31.1%) reside in the Northwest section of town.
The rationale for requesting funding for each project is based on the aforementioned need for additional mental health services in the county, and the existing waitlist. If MHMRA were to expand only one or two of the clinics, only 400-800 new consumers could be served and the waitlist would remain in effect. Additionally, it is expected that the need for mental health services will continue to grow, and therefore, limited expansion will simply not address the current needs of those on the waitlist or the community needs of those who initiated services with MHMRA.

**Unique Community Need Identification numbers:**
Specific community needs are also addressed through the proposed program:
- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Expansion of outpatient behavioral health services will address the community needs above by providing greater access to behavioral health care, thereby offsetting the increased use of medical and psychiatric emergency services. Furthermore, a larger behavioral health workforce within MHMRA will provide more opportunities for collaboration between providers and for patient education. MHMRA clinicians already engage in a variety of community collaborations and education activities, despite their tremendous workload. With the addition of qualified behavioral health personnel, more services can be provided.

**Goals and Relationship to Regional Goals:**
Goals include improving access to community mental health services by establishing additional service providers (e.g., an additional treatment team) among existing MHMRA community clinics in Harris County. Specifically, we aspire to place one new treatment team in the Northwest region. Each treatment team can serve roughly 500 consumers.

The proposed project directly meets broad goals identified by the regional needs assessment. First, it improves and builds upon an existing program, which has shown positive gains in providing best-practices for patient-centered care. Furthermore, by providing enhanced, evidence-based services to patients the program will meet the regional goal set out above. Moreover, the program supports the regional goal of developing a culture of patient-centered care whereby the patient/consumer plays a more active role as a stakeholder.

**Challenges:**
Workforce limitations may provide staff recruitment challenges requiring significant lead time and advanced planning. Clinic managers will work closely with human resources and administration to ensure timely staffing of the proposed treatment teams.

**Expected 5-year Outcomes:**
1) Staffing of the new team: 1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, 12 Rehabilitation Clinicians, 1 Administrative Assistant, 1 Clerical Support Staff, 1 Business Office Coordinator, and 1 HIT Staff.
2) Additional need is anticipated as initiatives to reduce 30-day re-hospitalizations, preventable emergency department visits, and jail recidivism, may create additional demand.

3) Provision of outpatient mental health service has been locally documented to reduce emergency psychiatric center visits by .37 visits per person per year; it has also has been shown to reduce public psychiatric hospital use by 1.66 bed days per person per year in a sample of 25,000 outpatients (served between the years 2005 and 2012).

4) Elimination of wait lists and improved geographic access can be expected to increase access to services, improved satisfaction, and decreased intensive service use. Reductions in intensive service (#3 and #4 above) use are firmly in line with regional project goals.

We expect to create a static capacity to treat 100 by Year 2, 250 by Year 3, and 500 in both years 4 and 5. Since the average length of stay in outpatient services is less than one year (about 11 months) numbers served will exceed the estimates of created treatment slots. We expect these patients to experience positive results from receiving the proposed treatment interventions. Specifically, we expect patients will improve their functional status due to a reduction in psychiatric symptoms, resulting in fewer psychiatric emergencies. Furthermore, because MHMRA believes it is vital to engage patients in their treatment we expect that patients will report increased levels of communication and collaboration with treatment providers. Because of the anticipated impact on patients, we chose the related improvement goals: increased utilization of behavioral health (I-11.1) and decreased emergency psychiatric service use (I-X).

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

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

IT-10.1: Demonstrate improvement in functional status

**Reasons/rationale for selecting the outcome measures:**

We believe patient satisfaction that addresses patient involvement in shared decision making and collaborative care, will reduce chronic over-use of psychiatric emergency services and in general reduce cost and improve efficiency. By enhancing service availability of appropriate levels of outpatient behavioral health care we will address the community needs. Also providing greater access to behavioral health care and the addition of qualified behavioral health care professionals will allow for the provision of more services, great patient satisfaction and improved patient outcomes. We will be using the applicable parts of CAPHS to access this aspect of patient satisfaction and will be setting a target of 10% improvement in patient satisfaction by the end of Year 5.

**IT-10.1: Functional Status**

We believe that our identified objective of transforming the current health care delivery system will be directly impacted by improving patient functioning. This transformation is proposed to be a patient-centered, coordinated delivery model that improves patient outcomes through better patient functioning. Based on this objective, the proposed program has identified the ANSA (Adult Needs and Strengths Assessment), as a targeted means to measure outcome
improvement goals. ANSA is a comprehensive assessment and outcome tool that measures both patient strengths that can be used to build on for patient growth and also patients needs for purposes of treatment planning and delivery. We expect that by DY5 there will be a 10% increase on at least one of the domains measured by the ANSA for patients in the program.

**Relationship to other Projects:**

The proposed project is similar to several MHMRA DSRIP proposals, including the expansion of outpatient behavioral health services within other clinics (113180703.1.4, 113180703.1.5, 113180703.1.6 and 113180703.1.7). Extending outpatient behavioral health specialty service and increasing the intensity of these services will together ultimately provide responsive, appropriate levels of care.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

**Relationship to Other Performing Providers’ Projects in the RHP:** TBD

**Plan for Learning Collaborative:**

Consumer satisfaction with access outcomes will be assessed with input from consumer groups involving both patients and family members in the quality improvement loop. Similarly, rates of public psychiatric hospitalization will be presented to public psychiatric hospital representatives with an invitation for them to provide input on the improvement process.

**Project Valuation:**

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

Cost-Utility Analysis: The Texas Recommended Assessment Guidelines (Texas Department of State Health Services, 2011) established a utilization management scheme for matching patient need to service packages of varying intensities. To provide an approximation of the value of an outpatient behavioral health program, we will review studies related to each of the four service packages described below as “levels of care.”

**Level One: Medication only**

Individuals receiving Service Package One (SP1) have been assessed to have relatively less severe symptomatology and functional impairment. Therefore, they receive medications only accompanied by service coordination. A study by Chouinard and Albright (1997) found that individuals receiving medications versus a placebo gained 7 times the quality-adjusted years than without medications (QALY = .125). The proportion of individuals recommended to Level One at MHMRA is 56.5%. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

\[
\begin{align*}
100 & \quad \text{(persons served)} \\
0.125 & \quad \text{(QALY gained)} \\
.565 & \quad \text{(proportion of patients recommended to Level One)} \\
\times & \quad \text{$50,000 \quad \text{(life year value)} } \\
= & \quad $353,125 \quad \text{Level 1 QALY Value}
\end{align*}
\]

**Level Two: Medication plus therapy**

About 18.5% of patients at MHMRA are recommended to Level Two services based on moderately severe need accompanied by diagnoses of major depression. This service package includes cognitive psychotherapy for depressive disorders in addition to medications. Pyne et al. (2003) compared the cost-effectiveness of medication services to medication plus CBT for depression. Their randomized controlled trial yielded an incremental QALY of 0.041 for the addition of CBT. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

\[
\begin{align*}
100 & \quad \text{(persons served)} \\
0.041 & \quad \text{(QALY gained)} \\
.185 & \quad \text{(proportion of patients recommended to Level 2)} \\
\times & \quad \text{$50,000 \quad \text{(life year value)} } \\
= & \quad $37,925 \quad \text{Level 2 QALY Valuation}
\end{align*}
\]

**Level Three: Medications and skills training**

About 24% of patients at MHMRA are recommended to Level Three services, based on higher severity symptom and functional skill impairment. This package includes medications and skills training. Barton and colleagues (2009) compared social recovery oriented cognitive behavioral therapy (SRCBT) for people diagnosed with psychosis compared to case management alone (CMA); they reported a mean incremental QALY gain of 0.035. Assuming the program would serve 100 persons in a year; the following formula shows the valuation:
100 (persons served)  
0.035 (QALY gained)  
0.24 (proportion of patients recommended to Level 3)  
× $50,000 (life year value)  
= $42,000 Level 3 QALY Value

**Level Four: Assertive Community Treatment (ACT) for Persons with Serious Mental Illness**

Of consumers referred for services, about 4.1% are recommended for ACT Team treatment. This level of care represents the highest intensity service intervention. A 2012 study reported the cost-effectiveness of assertive community treatment as part of integrated care versus standard care in patients with schizophrenia (Karow, Reimer, König, Heider, Bock & Huber 2012). Results indicated the ACT intervention yielded a QALY of 0.76, whereas the treatment as usual groups resulted in a QALY of 0.66. Since the treatment is being contrasted with wait list or not treatment, the full QALY (0.76) applies. The incremental QALY for the ACT group was 0.10. Assuming the program would serve 100 persons in a year the following formula shows the valuation:

\[
100 \text{ (persons served)} \times 0.76 \text{ (QALY gained)} \times 0.041 \text{ (Proportion of patients recommended to Level Four)} \times 50,000 \text{ (life year value)} = 155,800 \text{ Level 4 QALY Value}
\]

**Hospitalizations**

When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 1.66 fewer public psychiatric hospital bed days per person. Cost savings from these individuals from averting hospital services can be calculated as follows:

\[
100 \text{ (persons served)} \times 1.66 \text{ (average hospital bed days per person per year averted)} \times 700 \text{ (cost of hospital day)} = 116,200 \text{ Costs saved from averted hospitalizations}
\]

**Public Psychiatric Emergency Visits**

When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.212 fewer public psychiatric emergency room visits per person. Cost savings from these individuals from averting these emergency services can be calculated as follows:

\[
100 \text{ (persons served)} \times 0.212 \text{ (average emergency service visits per person per year averted)} \times 705 \text{ (cost of hospital day)} = 14,946 \text{ Costs saved from averted hospitalizations}
\]

**Mental Health Services in the County Jail**
When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.05 fewer county jail incarcerations per person. Cost savings from averting these jail bookings can be calculated as follows:

\[
\begin{align*}
\text{Persons Served} & = 100 \\
\text{Average Jail Incarcerations Per Person Per Year Averted} & = 0.05 \\
\text{Average Days Incarcerated} & = 40.6 \\
\text{Cost of Jail Day With Mental Health Service} & = \$130 \\
\text{Cost Saved From Averted Hospitalizations} & = 40.6 \times 130 = \$26,390
\end{align*}
\]

**Valuation Summary:** This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). Summing the estimated utilities of all four levels of care above, the expected value of this proposal is $746,386 per 100 people served per year.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1: P-2.** Identify licenses, equipment requirements and other components needed to implement and operate options selected.  
**Metric 1: P-2.5.1** Develop a project plan and timeline detailing operational needs and equipment and components  
**Data Source:** Written Project Plan  
**Goal:** Complete project plan within timeline to start providing services in DY 3

**Milestone 3: P-6: Establish behavioral health services in new community-based settings in underserved areas**  
**Metric 1: P-6.1** Number of new community-based settings where behavioral health services are delivered  
**Data Source:** Project documentation and MHMRA records  
**Goal:** Provide documentation of at least 250 patients being served by new treatment team

**Milestone 6: I-11: Increased utilization of community behavioral healthcare**  
**Metric 1: I-11.1** Percent utilization of community behavioral healthcare services.  
**Data Source:** MHMRA records  
**Goal:** Serve 500 patients more than baseline

**Estimated Incentive Payment:** $1,493,333.07  
**Estimated Incentive Payment:** $1,094,430.09  
**Estimated Incentive Payment:** $1,754,273.38  
**Estimated Incentive Payment:** $1,694,950.12
<table>
<thead>
<tr>
<th>Unique Identifier: 113180703.1.1</th>
<th>RHP PP Reference Number: 1.12.2</th>
<th>Project Components: NA</th>
<th>Program Title: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - NW</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td>TPI: 113180703</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Measure(s): Patient Satisfaction Functional Assessment</td>
<td>Unique Category 3 Project ID: 113180703.3.1 113180703.3.22</td>
<td>IT-6.1 IT-10.1</td>
<td>Percent improvement over baseline of patient satisfaction scores Improvement in functional status</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Milestone 2: P-4:</strong> Hire and train staff to operate and manage project <strong>Metric 1: P-4.1:</strong> Number of staff secured and trained <strong>Data Source:</strong> HR records <strong>Goal:</strong> hire staff for one additional treatment team</td>
<td><strong>Milestone 4:</strong> I-11 Increased utilization of community behavioral healthcare <strong>Metric 1:</strong> I-11.1 Percent utilization of community behavioral healthcare services. <strong>Data Source:</strong> MHMRA records <strong>Goal:</strong> establish baseline</td>
<td><strong>Milestone 7:</strong> I-X. Reduction in Inpatient Psychiatric Admissions (HCPC) <strong>Metric 1:</strong> I-X.1. Percent of individuals who were admitted to inpatient facilities. Denominator: Number of patients served by program Numerator: Number of patients served in OP clinic who admitted to HCPC <strong>Data Source:</strong> MHMRA and HCPC records <strong>Goal:</strong> A 5% decrease from baseline in HCPC admissions</td>
<td><strong>Milestone 9:</strong> I-X. Reduction in Inpatient Psychiatric Admissions (HCPC) <strong>Metric 1:</strong> I-X.1. Percent of individuals who were admitted to inpatient facilities. Denominator: Number of patients served by program Numerator: Number of patients served in OP clinic who admitted to HCPC <strong>Data Source:</strong> MHMRA and HCPC records <strong>Goal:</strong> A 10% decrease from baseline in HCPC admissions</td>
</tr>
<tr>
<td>Estimated Incentive Payment: $1,493,333.07</td>
<td>Estimated Incentive Payment: $1,094,430.09</td>
<td>Estimated Incentive Payment: $1,754,273.38</td>
<td>Estimated Incentive Payment: $1,694,950.12</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td><strong>Milestone 5</strong>: I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions <strong>Metric 1</strong>: I-X.1. Percent of individuals who were admitted to inpatient facilities. <strong>Data Source</strong>: Psychiatric Emergency Services (PES) records are part of the MHMRA electronic record. Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records. <strong>Goal</strong>: Establish baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment</strong>: $1,094,430.09</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $2,986,666.15</td>
<td>Year 3 Estimated Milestone Bundle Amount: $3,283,290.27</td>
<td>Year 4 Estimated Milestone Bundle Amount: $3,508,546.76</td>
<td>Year 5 Estimated Milestone Bundle Amount: $3,389,900.24</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong>: $13,168,403.42</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
REFERENCES


1.9 Expand Specialty Care Capacity: 1.9.2 - IDD Specialized Treatment and Rehabilitation Services (STARS)

RHP Project Number: 113180703.1.3

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) proposes to improve access to specialty care for children and adults with co-occurring psychiatric/behavioral and Intellectual and Developmental Disabilities (IDD) by expanding services and staffing. MHMRA is a community mental health treatment organization in Houston, Texas. As the local mental health authority, the agency serves primarily indigent patients. The proposed project seeks to expand outpatient specialty services for children and adults with complex co-occurring psychiatric/behavioral and Intellectual and Developmental Disabilities (IDD) or Autism Spectrum Disorders (ASD) by increasing staffing at MHMRA’s Specialized Treatment and Rehabilitative Services (STARS) clinic. This project meets the Delivery System Incentive Reform Payment (DSRIP) Pool 1115(a) waiver component 1.9, Enhance service availability to appropriate levels of care option 1.9.2 Improve access to specialty care.

Goals and Relationship to Regional Goals:
The primary goal of the project is to expand capacity for specialized behavioral health services to people with Intellectual and Developmental Disabilities (IDD) and/or Autism Spectrum Disorders (ASD) and co-occurring mental illness. This expansion is expected provide access to outpatient treatment that will decrease the severity of psychiatric symptoms in the target population and are expected to be reflected in improved patient satisfaction. In addition, the expanded services will be used as a training site to develop the skills of new clinicians for treating the target population. These goals are consistent with the regional goals and community needs discussed below.

Regional Goals:
The project will increase access to specialty care in Harris County and will transform behavioral healthcare for the target population by providing timely, coordinated clinical care. When the behavioral health needs of people with IDD/ASD and mental illness are not treated until a crisis occurs, resulting interventions focus on episodic, emergent care without adequate coordination of aftercare. The project will provide coordinated care to prevent crises or resolve them with successful transition into stable maintenance. Furthermore, by increasing training capacity for new professionals, this project will develop a skilled workforce to multiply community options and improve access to treatment while improving satisfaction and behavioral health outcomes for the target population.

Challenges:
One of the challenges will be hiring and training the appropriate level of staff to provide increased access and service to the targeted population. The proposed project will develop the
workforce of clinicians who are competent to work with the target population and are comfortable doing so. MHMRA will continue to build upon existing partnerships with local universities, medical schools, public and private Medicaid providers and other agencies to develop clinicians who are skilled and willing to treat people with IDD/ASD, thereby growing an ever-expanding pool of competent community providers. The contractual agreements between MHMRA and medical schools and universities are already in place to provide internships and practicum opportunities to students and residents in child psychiatry, psychology, nursing, and social work. The results of pre/post surveys of training for child psychiatry residents show that there is a consistent increase in both content knowledge related to IDD and subjective comfort level with evaluation/treatment of persons with co-morbid IDD and psychiatric illness following the training rotation offered by MHMRA’s IDD Division. Expansion of the clinic will allow MHMRA to reach a larger pool of clinicians and provide training stipends to encourage greater participation.

5-Year Expected Outcome for Provider and Patients:
MHMRA expects that the proposed project would result in increased utilization of specialty care services for as many as 500 patients in DY4 to 600 patients by DY5. The following table illustrates the estimated flow of patients by DY.

<table>
<thead>
<tr>
<th></th>
<th>DY2</th>
<th>DY3</th>
<th>DY4</th>
<th>DY5</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patients</td>
<td>60</td>
<td>100</td>
<td>150</td>
<td>200</td>
</tr>
<tr>
<td>Patients with increased utilization of needed specialty care*</td>
<td>0</td>
<td>50</td>
<td>350</td>
<td>400</td>
</tr>
<tr>
<td>DY Total</td>
<td>60</td>
<td>150</td>
<td>500</td>
<td>600</td>
</tr>
</tbody>
</table>

*Patients in this group may be carried over from previous year or be currently underserved and waiting for additional resources

Starting Point/Baseline:
The STARS clinic serves approximately 400 people with IDD/ASD and co-occurring mental illness are annually through outpatient clinic services. In an analysis conducted in 2006, the agency noted a 97% reduction in hospitalization rate, which represents a cost savings for the community and provides patient care in less restrictive settings. The clinic is staffed with one Psychiatrist, two Licensed Clinical Psychologists, one LCSW, one LVN, one RN, one Board Certified Behavior Analyst and one LPC/Director. All of these clinicians specialize in co-occurring mental illness and developmental disabilities. Current clinical space will be used in addition to redesigning available MHMRA space or seeking additional space as needed to house additional staff over the DSRIP period.

Rationale:
The existence of co-occurring mental illness in people with IDD/ASD has been widely recognized; however, treatment of psychiatric conditions in this population is still in its infancy, with unremarkable treatment outcomes. Poor treatment outcomes include more frequent psychiatric hospitalizations; longer admissions and later identification in the psychiatric event, resulting in higher levels of care. Furthermore, studies examining the treatment of co-occurring disorders report that mental health clinicians, including psychiatrists, psychologists, social
workers, nurses and other disciplines, are rarely formally trained to treat people with IDD/ASD and MI. Lack of exposure to people with developmental disabilities causes clinicians to shy away from these patients; and when they do become involved, they intervene later in the course of the disease process and tend to use medication for sedating purposes and not in accordance with the person's mental illness.

Texas has documented similar concerns. In May 2011, the directors of IDD programs in MHMRs across Texas were queried about the resources in their areas for responding to behavioral crises. Across the state they reported a lack of skilled clinicians and also noted psychiatric hospitals often refused inpatient services to individuals with co-morbid IDD and psychiatric illness in crisis because they lacked expertise in the population. Conversely, when admitted, they had extended inpatient stays with little improvement in behavioral functioning. With no other alternative in Texas, communities turn to institutional care in State Supported Living Centers (formerly called State Schools) to manage and treat these individuals. This is an expensive choice. The current annual cost for a person with IDD in a state supported living center is $177,624.

Harris County also has documented similar needs. Approximately 106,494 Harris County residents are diagnosed with an intellectual and developmental disability; 24,000 with autism spectrum disorder; and of people in these groups, 38,700 are dually diagnosed with co-occurring mental illness. Like the rest of the state, a behavioral health service for these individuals is a specialty that is lacking in Harris County. In response to this service gap, MHMRA developed a specialty outpatient clinic for people with co-occurring disorders; however, the need far exceeds the capacity of the current clinic. MHMRA has a waiting list of over 900 people for clinic services, yet the current capacity remains at 400. MHMRA of Harris County proposes to expand an innovative outpatient option, the Specialized Treatment and Rehabilitative Services (STARS) clinic by hiring 7 new staff members, to provide behavioral medicine and behavioral support services to create a safety net for people with IDD/ASD and co-occurring mental illness who reside in Harris County. The existing STARS clinic has been in operation for over 20 years with outpatient services that include assessment, parent/caregiver training, casework, medication management and education, and skills training to address the behavioral health needs of persons with dual diagnoses of IDD/ASD and mental illness, and whose needs exceed the capacity and expertise of the existing mental health system. However, the demand for services far exceeds the clinic’s capacity.

STARS is a unique clinic with highly skilled clinicians and IDD/ASD specialists who work together to achieve positive outcomes for people with serious behavioral and/or mental health problems. Clinicians and specialty paraprofessionals provide traditional therapies adapted for people with IDD/ASD and mental illness, family interventions and in-home applied behavior analysis training for families. The proposed expansion would add one psychiatrist, one clinical psychologist, two behavior analysts, one RN, two specialized trainers and administrative supports to extend the safety net to private families and to the Medicaid provider network who are unable to find expertise among available clinicians in Harris County.

**Project Components:**
Through the expansion of specialty care services project, we propose to meet all required project components listed below and believe that the selected milestones and metrics relate to the project components.

a) Increase service availability with extended hours
b) Increase number of specialty clinic locations  
c) Implement transparent, standardized referrals across the system  
d) Conduct quality improvement for project using methods such as rapid cycle improvement

Milestones and Metrics:  
The goals are consistent with the regional goals and community needs discussed above. Furthermore, the improvement metrics chosen for this project (I-23.1: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services) will determine the progress MHMRA is making to meet our stated goals. Specific measures will include the reduction of psychiatric/behavioral symptoms, improved patient satisfaction and increased number of clinical trainees rotating through outpatient services.

Unique community need identification number the project addresses:  
Expansion of the STARS clinic will address the following community needs:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions
- CN18- Insufficient access to integrated care programs for behavioral health and physical health conditions

Related Category 3 Outcome Measure(s):  
IT 6.1 Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction.
IT-9.4 Other Outcome Improvement Target: Percent decrease in psychiatric symptoms that provoke behavioral crises

Rationale for selecting the outcome measures:  
Harris County MHMRA proposes to expand an innovative outpatient option, the Specialized Treatment and Rehabilitative Services (STARS) clinic, to provide behavioral medicine and behavioral support services to create a safety net for people with IDD/ASD and co-occurring mental illness who reside in Harris County. This program is a unique clinic with highly skilled clinicians and IDD/ASD specialists who work together to achieve positive outcomes for people with serious behavioral and/or mental health problems. Clinicians and specialty paraprofessionals provide traditional therapies adapted for people with IDD/ASD and mental illness, family interventions and in-home applied behavior analysis training for families. The focus of these services is to reduce behavioral symptoms of co-occurring psychiatric illness as measured by the Reiss Screen for Maladaptive Behavior, an instrument designed specifically for the target population and used in numerous research and clinical settings to measure treatment effects. The impact is ultimately best measured through patient satisfaction as they provide the appropriate level of care for this critical population.

Relationship to Other Projects:  
This proposed project has activities related to the following MHMRA proposals: IDD Consultation and Liaison Service and IDD/ASD Wrap-around and In-home Services.
The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

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

**Project Valuation:**  
In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

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

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature.

**Cost-Utility Analysis:** Expansion of the current STARS-ABA program will provide resources for the 900 currently awaiting services. About 40% of the average population of IDD/ASD patients has a comorbid psychiatric diagnosis, most commonly depression, psychosis or ADHD. Many dually diagnosed individuals are within the mild to moderate range of intellectual impairment, making CBT a viable treatment. Due to resource limitations, many are receiving
only medication and service coordination when cognitive behavior therapy (CBT) is a recommended service.

Schoenbaum et al. (2001) compared the cost-effectiveness of medication services to medication plus CBT for depression. Their randomized controlled trial yielded an incremental QALY of 0.0226 for the addition of CBT. Applying this estimate to the current population the value of enhancing services for these underserved individuals can be calculated as follows:

\[
\text{QALY Value} = \frac{100}{(\text{persons served})} \times 0.40 \times 0.0226 \times \$50,000
\]

\[
= \$45,200
\]

Cost Savings: Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. We did identify a benefit-cost study that is related.

MHMRA’s existing STARS clinic sees approximately 400 people with IDD/ASD and co-occurring mental illness annually through outpatient clinic services. Estimates have put the rate of co-occurring mental health problems, such as depression and schizophrenia among this population as high as 40% making the treatment of these individuals more complex and costly (Lai, Hung, Lin, Chien & Lin, 2011; Tsakanikos, Sturmey, Costello, Holt & Bouras, 2007). After the implementation of this service in 1999, the inpatient hospitalization rate was 97% lower for individuals who received services in the following fiscal year. The average cost of inpatient hospitalization in the Harris County Hospital District is $700 per day, with an average length of stay for IDD/AS patients of 11.89 days (SD=8.13, N=524). Based on these findings the cost savings can be calculated as follows:

\[
\text{Cost Savings: Hospitalization} = \frac{0.05}{(\text{percent hospitalized prior to treatment})} \times \frac{100}{(\text{persons served})} \times 0.97 \times 11.89 \times \$700
\]

\[
= \$40,366
\]

Since hospital costs are included in the alternative method presented below, these costs are not separately claimed in the valuation.

**Alternative Cost Offset Estimation**

An additional study provides evidence that additional costs will be reduced by the implementation of specific behavioral treatments, such as ABA to the IDD/ASD population. The effectiveness of ABA has been well documented. By using a randomized, single-blind controlled study that compared treatment as usual with the use of a specialized team, similar to the proposed STARS program, in addition to treatment as usual, significant cost savings and improvements were noted on the Lethargy and Hyperactivity subscales (p<.008) of the Aberrant Behavior Checklist (Hassiotis, Robotham, Canagasabey, Romeo, Langridge, Blizard, Murad &
This study also found that at the end of a 6 month trial the costs for the treatment group were £2200 UK ($3,525 US) less than for the control when cost offset was calculated for increased community supports by the control group. When applied to 100 served individuals, a savings of $352,500 per 100 served.

**Summary and Total Valuation:** This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). The total valuation is ($45,200 QALY-based estimate plus $352,500 cost offset estimation) $397,700 per 100 people served per year.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1:** P-21 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects

**Metric 1:** P-21.2
Implement the “raise the floor” improvement initiatives established at the semiannual meeting.

**Data Source:** written documentation

**Estimated Incentive Payment:** $379,548.40

**Milestone 5:** P-21 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects

**Metric 2:** P-21.2
Implement the “raise the floor” improvement initiatives established at the semiannual meeting.

**Data Source:** written documentation

**Estimated Incentive Payment:** $416,993.68

**Milestone 9:** P-21 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects

**Metric 1:** P-21.1
Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Data Source:** written documentation

**Estimated Incentive Payment:** $891,238.99

**Milestone 12:** P-21 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects

**Metric 1:** P-21.1
Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Data Source:** written documentation

**Estimated Incentive Payment:** $861,083.56

**Milestone 13:** P-21 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects

**Metric 1:** P-21.1
Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Data Source:** written documentation

**Estimated Incentive Payment:** $861,083.56
<table>
<thead>
<tr>
<th>milestone</th>
<th>description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 3</td>
<td>P-1: Conduct specialty care gap assessment based on community need</td>
</tr>
<tr>
<td><strong>Metric 1</strong>: P-1.1</td>
<td>Documentation of gap assessment.</td>
</tr>
<tr>
<td><strong>Data source</strong>:</td>
<td>Needs Assessment</td>
</tr>
<tr>
<td><strong>Goal</strong>:</td>
<td>establish baseline of community needs</td>
</tr>
<tr>
<td>Milestone 7</td>
<td>Collect baseline data for wait times, backlog, and/or return appointments in specialties</td>
</tr>
<tr>
<td><strong>Metric 1</strong>:</td>
<td>P-3.1. Establish baseline for performance indicators</td>
</tr>
<tr>
<td>Metric 1a</td>
<td>Numerator: TBD by the Performing Provider</td>
</tr>
<tr>
<td>Metric 1b</td>
<td>Denominator: TBD by the Performing Provider</td>
</tr>
<tr>
<td><strong>Data Source</strong>:</td>
<td>Anasazi, client records</td>
</tr>
<tr>
<td><strong>Baseline</strong>:</td>
<td>current documentation of waitlist needs to be revised for stated goals</td>
</tr>
<tr>
<td><strong>Goal</strong>:</td>
<td>establish baseline wait times</td>
</tr>
<tr>
<td>Milestone 11</td>
<td>Increase TSC training and/or rotations</td>
</tr>
<tr>
<td><strong>Metric 1</strong>:</td>
<td>I-31.2. Increase the number of TSC trainees rotating at the Performing Provider’s facilities</td>
</tr>
<tr>
<td>Metric 1a</td>
<td>Number of TSC trainees in Performing Provider’s facility</td>
</tr>
<tr>
<td>Metric 1b</td>
<td>Data Source: Student/trainee rotation schedule</td>
</tr>
<tr>
<td>Metric 1c</td>
<td>Rationale/Evidence: As the goal is to increase the TSC workforce to better meet the need for TSC in the health care system by increasing training of the TSC workforce in Texas, the metric is a straightforward measurement of increased training.</td>
</tr>
<tr>
<td>Milestone 14</td>
<td>Increase TSC training and/or rotations</td>
</tr>
<tr>
<td><strong>Metric 1</strong>:</td>
<td>I-31.2. Increase the number of TSC trainees rotating at the Performing Provider’s facilities</td>
</tr>
<tr>
<td>Metric 1a</td>
<td>Number of TSC trainees in Performing Provider’s facility</td>
</tr>
<tr>
<td>Metric 1b</td>
<td>Data Source: Student/trainee rotation schedule</td>
</tr>
<tr>
<td>Metric 1c</td>
<td>Rationale/Evidence: As the goal is to increase the TSC workforce to better meet the need for TSC in the health care system by increasing training of the TSC workforce in Texas, the metric is a straightforward measurement of increased training.</td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>$379,548.40</td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>$416,993.68</td>
</tr>
<tr>
<td>Milestone 4</td>
<td>P-11: Launch/expand a specialty care clinic</td>
</tr>
<tr>
<td><strong>Metric 1</strong>:</td>
<td>P-11.1: Establish/expand STARS specialty care clinics</td>
</tr>
<tr>
<td>Metric 1a</td>
<td>Number of patients served by specialty care clinic</td>
</tr>
<tr>
<td>Metric 1b</td>
<td>Data Source: Documentation of new/expanded specialty care clinic</td>
</tr>
<tr>
<td>Milestone 8</td>
<td>P-5: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment</td>
</tr>
<tr>
<td><strong>Metric 1</strong>:</td>
<td>Generate and provide reports on average referral process time and/or time to appointment</td>
</tr>
<tr>
<td>Metric 1a</td>
<td>Data Source: EHR, Anasazi</td>
</tr>
<tr>
<td>Metric 1b</td>
<td>Baseline: establish current baseline</td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>$379,548.40</td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>$416,993.68</td>
</tr>
<tr>
<td>Year 2 Est. Bundle Amount:</td>
<td>$1,518,193.61</td>
</tr>
<tr>
<td>Year 3 Est. Bundle Amount:</td>
<td>$1,667,974.73</td>
</tr>
<tr>
<td>Year 4 Est. Bundle Amount:</td>
<td>$1,782,477.97</td>
</tr>
<tr>
<td>Year 5 Est. Bundle Amount:</td>
<td>$1,722,167.12</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $6,690,813.44
References


1.12 Enhance service availability of appropriate level of behavioral health care: Expansion of outpatient behavioral health services for adults with severe psychiatric conditions (Northeast)

RHP Project Number: 113180703.1.4

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to increase outpatient capacity to potentially eliminate the current wait list for services in this geographic area.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. In an effort to provide needed services to the most critically ill population, MHMRA proposes to increase outpatient capacity by approximately 500 individuals potentially eliminating the current wait list for services in this geographic area. In order to address this issue we will choose to focus on project option 1.12.2: Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

It is important to note that we are proposing four similar projects, each under the 1.12.2 umbrella, which would expand outpatient behavioral health services for adults in each of our existing clinics. Outpatient services for this program include psychopharmacological interventions, provision of psychiatric medications to the medically uninsured, case management, psychosocial skills training and psychotherapy, family therapy and linkages to needed resources in the community. Each of the expansion program serves unique geographical needs, and therefore, each of the projects are critical to addressing the community needs.

MHMRA of Harris County provides adult mental health outpatient services to patients with serious mental illness according to a utilization management scheme intended to provide the right level of service matching the assessed severity of need. The majority of patients (78%) receive Level One service. This mix of assessment, case management and psychiatric treatment averages 13.44 hours per patient per year. At Medicaid reimbursement rates, these services would be valued at $1,209 per patient per year. In addition, MHMRA provides medications to the medically indigent at a rate of $2036 per person per year. The combined value of staff services and medications is estimated at $3,255 per person per year for this (lowest) utilization management group. The Level Two package adds cognitive behavior therapy for major depression to the service mix. Although the package averages nearly three times the service
hours per person, the reimbursement rate is just slightly higher. Level Threes services include psychosocial skills training, doubling the hours of service over package Two, at a rate of $4,317 per person per year. Finally, Assertive Community Treatment (ACT) is the most intense and expensive package reserved for those most in need at an estimated cost/value of $6,975 per person.

### Per Person Per Year Estimates of Costs/Values of Services x Level of Care

<table>
<thead>
<tr>
<th>Level</th>
<th>Proportion of Patients</th>
<th>Annual # Services per Patient</th>
<th>Annual Hours of Service per Patient</th>
<th>Annual Value of Services*</th>
<th>Annual Value of Medications</th>
<th>Total Cost/Value of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level One</td>
<td>78%</td>
<td>39.08</td>
<td>13.44</td>
<td>$1,219</td>
<td>$2,036</td>
<td>$3,255</td>
</tr>
<tr>
<td>Level Two</td>
<td>9%</td>
<td>63.23</td>
<td>34.5</td>
<td>$1,244</td>
<td>$2,036</td>
<td>$3,280</td>
</tr>
<tr>
<td>Level Three</td>
<td>10%</td>
<td>131.28</td>
<td>68.05</td>
<td>$2,281</td>
<td>$2,036</td>
<td>$4,317</td>
</tr>
<tr>
<td>ACT</td>
<td>1%</td>
<td>387.53</td>
<td>187.86</td>
<td>$4,939</td>
<td>$2,036</td>
<td>$6,975</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>59.12</td>
<td>25.26</td>
<td>$1,428</td>
<td>$2,036</td>
<td>$3,464</td>
</tr>
</tbody>
</table>

*2012 Medicaid Reimbursement Rates

**Starting Point/Baseline:**
As mentioned previously, 8,800 consumers are served among the four existing outpatient clinics. By adding the five teams proposed under the five related projects, the total adult outpatient capacity would be expanded to 11,300 treatment slots. The current project will add 500 of the expansion slots by DY4 and continuing through DY5. Current clinical space will be used in addition to redesigning available MHMRA space or seeking additional space as needed to house additional staff over the DSRIP period.

**Rationale:**
The community mental health system in Harris County has a limited capacity for service that is insufficient to the needs of its residents. The Mental Health Needs Council of Harris County has estimated that 153,000 of the 552,000 Harris County adults with mental illness have a severe mental illness (Depression, Bipolar Disorder, and Schizophrenia). These individuals are among the 96,200 Harris County adults who have no public (Medicaid or Medicare) or private health insurance and therefore, are totally dependent on the public mental health service system for treatment. In 2007, approximately 27,000 adults received services from the public mental health system; 18,200 of these were uninsured (a number representing only 19% of estimated need). By deduction, one can conclude that approximately 78,000 adults with severe mental illness failed to access treatment from the public or private mental health systems.

The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the waiting list for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service.

On August 31 (2012), the MHMRA waitlist for adult mental health outpatient services rested at 1,695, a level that has persisted for several years. Further, tenure on the waiting list...
approached five months, an average of 149.16 days. The majority of consumers on the MHMRA waitlist (31.1%) reside in the Northeast section of town.

The rationale for requesting funding for each project is based on the aforementioned need for additional mental health services in the county, and the existing waitlist. If MHMRA were to expand only one or two of the clinics, only 400-800 new consumers could be served and the waitlist would remain in effect. Additionally, it is expected that the need for mental health services will continue to grow, and therefore, limited expansion will simply not address the current needs of those on the waitlist or the community needs of those who initiated services with MHMRA.

**Unique Community Need Identification numbers:**
Specific community needs are also addressed through the proposed program:
- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Expansion of outpatient behavioral health services will address the community needs above by providing greater access to behavioral health care, thereby offsetting the increased use of medical and psychiatric emergency services. Furthermore, a larger behavioral health workforce within MHMRA will provide more opportunities for collaboration between providers and for patient education. MHMRA clinicians already engage in a variety of community collaborations and education activities, despite their tremendous workload. With the addition of qualified behavioral health personnel, more services can be provided.

**Goals and Relationship to Regional Goals:**
Goals include improving access to community mental health services by establishing additional service providers (e.g., an additional treatment team) among existing MHMRA community clinics in Harris County. Specifically, we aspire to place one new treatment team in the Northeast region. Each treatment team can serve roughly 500 consumers.

The proposed project directly meets broad goals identified by the regional needs assessment. First, it improves and builds upon an existing program, which has shown positive gains in providing best-practices for patient-centered care. Furthermore, by providing enhanced, evidence-based services to patients the program will meet the regional goal set out above. Moreover, the program supports the regional goal of developing a culture of patient-centered care whereby the patient/consumer plays a more active role as a stakeholder.

**Challenges:**
Workforce limitations may provide staff recruitment challenges requiring significant lead time and advanced planning. Clinic managers will work closely with human resources and administration to ensure timely staffing of the proposed treatment teams.

**Expected 5-year Outcomes:**
- Staffing of the new team: 1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, 12 Rehabilitation Clinicians, 1 Administrative Practitioners of the Healing Arts, 1 Administrative Assistant, 1 Clerical Support Staff, 1 Business Office Coordinator, and 1 HIT Staff.
6) Additional need is anticipated as initiatives to reduce 30-day re-hospitalizations, preventable emergency department visits, and jail recidivism, may create additional demand.

7) Provision of outpatient mental health service has been locally documented to reduce emergency psychiatric center visits by .37 visits per person per year; it has also has been shown to reduce public psychiatric hospital use by 1.66 bed days per person per year in a sample of 25,000 outpatients (served between the years 2005 and 2012).

8) Elimination of wait lists and improved geographic access can be expected to increase access to services, improved satisfaction, and decreased intensive service use. Reductions in intensive service (#3 and #4 above) use are firmly in line with regional project goals.

We expect to create a static capacity to treat 100 by Year 2, 250 by Year 3, and 500 in both years 4 and 5. Since the average length of stay in outpatient services is less than one year (about 11 months) numbers served will exceed the estimates of created treatment slots. We expect these patients to experience positive results from receiving the proposed treatment interventions. Specifically, we expect patients will improve their functional status due to a reduction in psychiatric symptoms, resulting in fewer psychiatric emergencies. Furthermore, because MHMRA believes it is vital to engage patients in their treatment we expect that patients will report increased levels of communication and collaboration with treatment providers. Because of the anticipated impact on patients, we chose the related improvement goals: increased utilization of behavioral health (I-11.1) and decreased emergency psychiatric service use (I-X).

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

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

IT-10.1: Demonstrate improvement in functional status

**Reasons/rationale for selecting the outcome measures:**

We believe patient satisfaction that addresses patient involvement in shared decision making and collaborative care, will reduce chronic over-use of psychiatric emergency services and in general reduce cost and improve efficiency. By enhancing service availability of appropriate levels of outpatient behavioral health care we will address the community needs. Also providing greater access to behavioral health care and the addition of qualified behavioral health care professionals will allow for the provision of more services, great patient satisfaction and improved patient outcomes. We will be using the applicable parts of CAPHS to access this aspect of patient satisfaction and will be setting a target of 10% improvement in patient satisfaction by the end of Year 5.

**IT-10.1: Functional Status**

We believe that our identified objective of transforming the current health care delivery system will be directly impacted by improving patient functioning. This transformation is proposed to be a patient-centered, coordinated delivery model that improves patient outcomes
through better patient functioning. Based on this objective, the proposed program has identified the ANSA (Adult Needs and Strengths Assessment), as a targeted means to measure outcome improvement goals. ANSA is a comprehensive assessment and outcome tool that measures both patient strengths that can be used to build on for patient growth and also patients needs for purposes of treatment planning and delivery. We expect that by DY5 there will be a 10% increase on at least one of the domains measured by the ANSA for patients in the program.

**Relationship to other Projects:**

The proposed project is similar to several MHMRA DSRIP proposals, including the expansion of outpatient behavioral health services within other clinics (113180703.1.1, 113180703.1.5, 113180703.1.6 and 113180703.1.7). Extending outpatient behavioral health specialty service and increasing the intensity of these services will together ultimately provide responsive, appropriate levels of care.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

**Relationship to Other Performing Providers’ Projects in the RHP:** TBD

**Plan for Learning Collaborative:**

Consumer satisfaction with access outcomes will be assessed with input from consumer groups involving both patients and family members in the quality improvement loop. Similarly, rates of public psychiatric hospitalization will be presented to public psychiatric hospital representatives with an invitation for them to provide input on the improvement process.

**Project Valuation:**

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

Cost-Utility Analysis: The Texas Recommended Assessment Guidelines (Texas Department of State Health Services, 2011) established a utilization management scheme for matching patient need to service packages of varying intensities. To provide an approximation of the value of an outpatient behavioral health program, we will review studies related to each of the four service packages described below as “levels of care.”

**Level One: Medication only**

Individuals receiving Service Package One (SP1) have been assessed to have relatively less severe symptomatology and functional impairment. Therefore, they receive medications only accompanied by service coordination. A study by Chouinard and Albright (1997) found that individuals receiving medications versus a placebo gained 7 times the quality-adjusted years than without medications (QALY = .125). The proportion of individuals recommended to Level One at MHMRA is 56.5%. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

\[
\text{Level 1 QALY Value} = 100 \times 0.125 \times 0.565 \times 50,000 = 353,125
\]

**Level Two: Medication plus therapy**

About 18.5% of patients at MHMRA are recommended to Level Two services based on moderately severe need accompanied by diagnoses of major depression. This service package includes cognitive psychotherapy for depressive disorders in addition to medications. Pyne et al. (2003) compared the cost-effectiveness of medication services to medication plus CBT for depression. Their randomized controlled trial yielded an incremental QALY of 0.041 for the addition of CBT. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

\[
\text{Level 2 QALY Valuation} = 100 \times 0.041 \times 0.185 \times 50,000 = 37,925
\]

**Level Three: Medications and skills training**

About 24% of patients at MHMRA are recommended to Level Three services, based on higher severity symptom and functional skill impairment. This package includes medications and skills training. Barton and colleagues (2009) compared social recovery oriented cognitive
behavioral therapy (SRCBT) for people diagnosed with psychosis compared to case management alone (CMA); they reported a mean incremental QALY gain of 0.035. Assuming the program would serve 100 persons in a year; the following formula shows the valuation:

\[
\begin{align*}
100 & \quad \text{(persons served)} \\
0.035 & \quad \text{(QALY gained)} \\
0.24 & \quad \text{(proportion of patients recommended to Level 3)} \\
\times $50,000 & \quad \text{(life year value)} \\
= $42,000 & \quad \text{Level 3 QALY Value}
\end{align*}
\]

**Level Four: Assertive Community Treatment (ACT) for Persons with Serious Mental Illness**

Of consumers referred for services, about 4.1% are recommended for ACT Team treatment. This level of care represents the highest intensity service intervention. A 2012 study reported the cost-effectiveness of assertive community treatment as part of integrated care versus standard care in patients with schizophrenia (Karow, Reimer, König, Heider, Bock & Huber, 2012). Results indicated the ACT intervention yielded a QALY of 0.76, whereas the treatment as usual groups resulted in a QALY of 0.66. Since the treatment is being contrasted with wait list or not treatment, the full QALY (0.76) applies. The incremental QALY for the ACT group was 0.10. Assuming the program would serve 100 persons in a year the following formula shows the valuation:

\[
\begin{align*}
100 & \quad \text{(persons served)} \\
0.76 & \quad \text{(QALY gained)} \\
0.041 & \quad \text{Proportion of patients recommended to Level Four} \\
\times $50,000 & \quad \text{(life year value)} \\
= $155,800 & \quad \text{Level 4 QALY Value}
\end{align*}
\]

**Hospitalizations**

When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 1.66 fewer public psychiatric hospital bed days per person. Cost savings from these individuals from averting hospital services can be calculated as follows:

\[
\begin{align*}
100 & \quad \text{(persons served)} \\
1.66 & \quad \text{(average hospital bed days per person per year averted)} \\
\times $700 & \quad \text{(cost of hospital day)} \\
= $116,200 & \quad \text{Costs saved from averted hospitalizations}
\end{align*}
\]

**Public Psychiatric Emergency Visits**

When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.212 fewer public psychiatric emergency room visits per person. Cost savings from these individuals from averting these emergency services can be calculated as follows:

\[
\begin{align*}
100 & \quad \text{(persons served)} \\
.212 & \quad \text{(average emergency service visits per person per year averted)} \\
\times $700 & \quad \text{(cost of hospital day)} \\
= $116,200 & \quad \text{Costs saved from averted emergency visits}
\end{align*}
\]
Mental Health Services in the County Jail

When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.05 fewer county jail incarcerations per person. Cost savings from averting these jail bookings can be calculated as follows:

100 \text{ (persons served)} \\
.05 \text{ (average county jail incarcerations per person per year averted)} \\
40.6 \text{ Average days incarcerated} \\
X$130 \text{ (cost of jail day with mental health service)} \\
= $26,390 \text{ Costs saved from averted hospitalizations}

Valuation Summary: This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). Summing the estimated utilities of all four levels of care above, the expected value of this proposal is $746,386 per 100 people served per year.
<table>
<thead>
<tr>
<th>Year</th>
<th>Milestone</th>
<th>Description</th>
<th>Data Source</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>Milestone 1: P-2</td>
<td>Identify licenses, equipment requirements and other components needed to implement and operate options selected. Metric 1: P-2.5.1 Develop a project plan and timeline detailing operational needs and equipment and components. <strong>Data Source:</strong> Written Project Plan</td>
<td><strong>Goal:</strong> Complete project plan within timeline to start providing services in DY 3</td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td>Milestone 3: P-6</td>
<td>Establish behavioral health services in new community-based settings in underserved areas. Metric 1: P-6.1 Number of new community-based settings where behavioral health services are delivered. <strong>Data Source:</strong> Project documentation and MHMRA records</td>
<td><strong>Goal:</strong> Provide documentation of at least 250 patients being served by new treatment team</td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td>Milestone 6: I-11</td>
<td>Increased utilization of community behavioral healthcare. Metric 1: I-11.1 Percent utilization of community behavioral healthcare services. <strong>Data Source:</strong> MHMRA records</td>
<td><strong>Goal:</strong> Serve 500 patients more than baseline</td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td>Milestone 8: I-11</td>
<td>Increased utilization of community behavioral healthcare. Metric 1: I-11.1 Percent utilization of community behavioral healthcare services. <strong>Data Source:</strong> MHMRA records</td>
<td><strong>Goal:</strong> Serve 500 patients more than baseline</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 2: P-4:** Hire and train staff to operate and manage project

**Metric 1: P-4.1:** Number of staff secured and trained

**Data Source:** HR records

**Goal:** Hire staff for one additional treatment team

**Milestone 4: I-11:** Increased utilization of community behavioral healthcare

**Metric 1: I-11.1:** Percent utilization of community behavioral healthcare services.

**Data Source:** MHMRA records

**Goal:** Establish baseline

**Milestone 7:** I-X. Reduction in Inpatient Psychiatric Admissions (HCPC)

**Metric 1:** I-X.1. Percent of individuals who were admitted to inpatient facilities.

Denominator: Number of patients served by program

Numerator: Number of patients served in OP clinic who admitted to HCPC

**Data Source:** MHMRA and HCPC records

**Goal:** A 5% decrease from baseline in HCPC admissions

**Milestone 9:** I-X. Reduction in Inpatient Psychiatric Admissions (HCPC)

**Metric 1:** I-X.1. Percent of individuals who were admitted to inpatient facilities.

Denominator: Number of patients served by program

Numerator: Number of patients served in OP clinic who admitted to HCPC

**Data Source:** MHMRA and HCPC records

**Goal:** A 10% decrease from baseline in HCPC admissions

**Estimated Incentive Payment:** $1,493,333.07

**Estimated Incentive Payment:** $1,094,430.09

**Estimated Incentive Payment:** $1,754,273.38

**Estimated Incentive Payment:** $1,694,950.12
**Program Title:** EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - NE

**RHP Performing Provider:** Mental Health and Mental Retardation Authority of Harris County

**Related Category 3 Measure(s):**
- Patient Satisfaction
- Functional Assessment

**Unique Category 3 Project ID:**
- 113180703.3.4
- 113180703.3.24

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

**IT-10.1**
- Improvement in functional status

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 5:** I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions

**Metric 1:** I-X.1. Percent of individuals who were admitted to inpatient facilities.

**Data Source:** Psychiatric Emergency Services (PES) records are part of the MHMRA electronic record. Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records

**Goal:** Establish baseline

**Estimated Incentive Payment:**

- Year 2 Estimated Milestone Bundle Amount: $2,986,666.15
- Year 3 Estimated Milestone Bundle Amount: $3,283,290.27
- Year 4 Estimated Milestone Bundle Amount: $3,508,546.76
- Year 5 Estimated Milestone Bundle Amount: $3,389,900.24

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $13,168,403.42
REFERENCES


1.12 Enhance service availability of appropriate level of behavioral health care: Expansion of outpatient behavioral health services for adults with severe psychiatric conditions (Southwest)

**RHP Project Number:** 113180703.1.5

**Performing Provider/TPI:** Mental Health and Mental Retardation Authority of Harris County/113180703

**Project Description:**

_The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to increase outpatient capacity to potentially eliminate the current wait list for services in this geographic area._

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. In an effort to provide needed services to the most critically ill population, MHMRA proposes to increase outpatient capacity by approximately 500 individuals potentially eliminating the current wait list for services in this geographic area. In order to address this issue we will choose to focus on project option 1.12.2: Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

It is important to note that we are proposing four similar projects, each under the 1.12.2 umbrella, which would expand outpatient behavioral health services for adults in each of our existing clinics. Outpatient services for this program include psychopharmacological interventions, provision of psychiatric medications to the medically uninsured, case management, psychosocial skills training and psychotherapy, family therapy and linkages to needed resources in the community. Each of the expansion program serves unique geographical needs, and therefore, each of the projects are critical to addressing the community needs.

MHMRA of Harris County provides adult mental health outpatient services to patients with serious mental illness according to a utilization management scheme intended to provide the right level of service matching the assessed severity of need. The majority of patients (78%) receive Level One service. This mix of assessment, case management and psychiatric treatment averages 13.44 hours per patient per year. At Medicaid reimbursement rates, these services would be valued at $1,209 per patient per year. In addition, MHMRA provides medications to the medically indigent at a rate of $2036 per person per year. The combined value of staff services and medications is estimated at $3,255 per person per year for this (lowest) utilization management group. The Level Two package adds cognitive behavior therapy for major depression to the service mix. Although the package averages nearly three times the service
hours per person, the reimbursement rate is just slightly higher. Level Threes services include psychosocial skills training, doubling the hours of service over package Two, at a rate of $4,317 per person per year. Finally, Assertive Community Treatment (ACT) is the most intense and expensive package reserved for those most in need at an estimated cost/value of $6,975 per person.

<table>
<thead>
<tr>
<th>Per Person Per Year Estimates of Costs/Values of Services x Level of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>Level One</td>
</tr>
<tr>
<td>Level Two</td>
</tr>
<tr>
<td>Level Three</td>
</tr>
<tr>
<td>ACT</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

*2012 Medicaid Reimbursement Rates

Starting Point/Baseline:
As mentioned previously, 8,800 consumers are served among the four existing outpatient clinics. By adding the five teams proposed under the five related projects, the total adult outpatient capacity would be expanded to 11,300 treatment slots. The current project will add 500 of the expansion slots by DY4 and continuing through DY5. Current clinical space will be used in addition to redesigning available MHMRA space or seeking additional space as needed to house additional staff over the DSRIP period.

Rationale:
The community mental health system in Harris County has a limited capacity for service that is insufficient to the needs of its residents. The Mental Health Needs Council of Harris County has estimated that 153,000 of the 552,000 Harris County adults with mental illness have a severe mental illness (Depression, Bipolar Disorder, and Schizophrenia). These individuals are among the 96,200 Harris County adults who have no public (Medicaid or Medicare) or private health insurance and therefore, are totally dependent on the public mental health service system for treatment. In 2007, approximately 27,000 adults received services from the public mental health system; 18,200 of these were uninsured (a number representing only 19% of estimated need). By deduction, one can conclude that approximately 78,000 adults with severe mental illness failed to access treatment from the public or private mental health systems.

The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the waiting list for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service.

On August 31 (2012), the MHMRA waitlist for adult mental health outpatient services rested at 1,695, a level that has persisted for several years. Further, tenure on the waiting list
approached five months, an average of 149.16 days. The majority of consumers on the MHMRA waitlist (31.1%) reside in the Southwest section of town.

The rationale for requesting funding for each project is based on the aforementioned need for additional mental health services in the county, and the existing waitlist. If MHMRA were to expand only one or two of the clinics, only 400-800 new consumers could be served and the waitlist would remain in effect. Additionally, it is expected that the need for mental health services will continue to grow, and therefore, limited expansion will simply not address the current needs of those on the waitlist or the community needs of those who initiated services with MHMRA.

**Unique Community Need Identification numbers:**
Specific community needs are also addressed through the proposed program:
- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Expansion of outpatient behavioral health services will address the community needs above by providing greater access to behavioral health care, thereby offsetting the increased use of medical and psychiatric emergency services. Furthermore, a larger behavioral health workforce within MHMRA will provide more opportunities for collaboration between providers and for patient education. MHMRA clinicians already engage in a variety of community collaborations and education activities, despite their tremendous workload. With the addition of qualified behavioral health personnel, more services can be provided.

**Goals and Relationship to Regional Goals:**
Goals include improving access to community mental health services by establishing additional service providers (e.g., an additional treatment team) among existing MHMRA community clinics in Harris County. Specifically, we aspire to place one new treatment team in the Southwest region. Each treatment team can serve roughly 500 consumers. The proposed project directly meets broad goals identified by the regional needs assessment. First, it improves and builds upon an existing program, which has shown positive gains in providing best-practices for patient-centered care. Furthermore, by providing enhanced, evidence-based services to patients the program will meet the regional goal set out above. Moreover, the program supports the regional goal of developing a culture of patient-centered care whereby the patient/consumer plays a more active role as a stakeholder.

**Challenges:**
Workforce limitations may provide staff recruitment challenges requiring significant lead time and advanced planning. Clinic managers will work closely with human resources and administration to ensure timely staffing of the proposed treatment teams.

**Expected 5-year Outcomes:**
9) Staffing of the new team: 1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, 12 Rehabilitation Clinicians, 1 Administrative Assistant, 1 Clerical Support Staff, 1 Business Office Coordinator, and 1 HIT Staff.
10) Additional need is anticipated as initiatives to reduce 30-day re-hospitalizations, preventable emergency department visits, and jail recidivism, may create additional demand.

11) Provision of outpatient mental health service has been locally documented to reduce emergency psychiatric center visits by .37 visits per person per year; it has also been shown to reduce public psychiatric hospital use by 1.66 bed days per person per year in a sample of 25,000 outpatients (served between the years 2005 and 2012).

12) Elimination of wait lists and improved geographic access can be expected to increase access to services, improved satisfaction, and decreased intensive service use. Reductions in intensive service (#3 and #4 above) use are firmly in line with regional project goals.

We expect to create a static capacity to treat 100 by Year 2, 250 by Year 3, and 500 in both years 4 and 5. Since the average length of stay in outpatient services is less than one year (about 11 months) numbers served will exceed the estimates of created treatment slots. We expect these patients to experience positive results from receiving the proposed treatment interventions. Specifically, we expect patients will improve their functional status due to a reduction in psychiatric symptoms, resulting in fewer psychiatric emergencies. Furthermore, because MHMRA believes it is vital to engage patients in their treatment we expect that patients will report increased levels of communication and collaboration with treatment providers. Because of the anticipated impact on patients, we chose the related improvement goals: increased utilization of behavioral health (I-11.1) and decreased emergency psychiatric service use (I-X).

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

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

IT-10.1: Demonstrate improvement in functional status

**Reasons/rationale for selecting the outcome measures:**

We believe patient satisfaction that addresses patient involvement in shared decision making and collaborative care, will reduce chronic over-use of psychiatric emergency services and in general reduce cost and improve efficiency. By enhancing service availability of appropriate levels of outpatient behavioral health care we will address the community needs. Also providing greater access to behavioral health care and the addition of qualified behavioral health care professionals will allow for the provision of more services, great patient satisfaction and improved patient outcomes. We will be using the applicable parts of CAPHs to access this aspect of patient satisfaction and will be setting a target of 10% improvement in patient satisfaction by the end of Year 5.

**IT-10.1: Functional Status**

We believe that our identified objective of transforming the current health care delivery system will be directly impacted by improving patient functioning. This transformation is proposed to be a patient-centered, coordinated delivery model that improves patient outcomes.
through better patient functioning. Based on this objective, the proposed program has identified the ANSA (Adult Needs and Strengths Assessment), as a targeted means to measure outcome improvement goals. ANSA is a comprehensive assessment and outcome tool that measures both patient strengths that can be used to build on for patient growth and also patients needs for purposes of treatment planning and delivery. We expect that by DY5 there will be a 10% increase on at least one of the domains measured by the ANSA for patients in the program.

**Relationship to other Projects:**

The proposed project is similar to several MHMRA DSRIP proposals, including the expansion of outpatient behavioral health services within other clinics (113180703.1.1, 113180703.1.4, 113180703.1.6 and 113180703.1.7). Extending outpatient behavioral health specialty service and increasing the intensity of these services will together ultimately provide responsive, appropriate levels of care.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

**Relationship to Other Performing Providers’ Projects in the RHP:** TBD

**Plan for Learning Collaborative:**

Consumer satisfaction with access outcomes will be assessed with input from consumer groups involving both patients and family members in the quality improvement loop. Similarly, rates of public psychiatric hospitalization will be presented to public psychiatric hospital representatives with an invitation for them to provide input on the improvement process.

**Project Valuation:**

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

**Cost-Utility Analysis: The Texas Recommended Assessment Guidelines (Texas Department of State Health Services, 2011) established a utilization management scheme for matching patient need to service packages of varying intensities. To provide an approximation of the value of an outpatient behavioral health program, we will review studies related to each of the four service packages described below as “levels of care.”**

**Level One: Medication only**

Individuals receiving Service Package One (SP1) have been assessed to have relatively less severe symptomatology and functional impairment. Therefore, they receive medications only accompanied by service coordination. A study by Chouinard and Albright (1997) found that individuals receiving medications versus a placebo gained 7 times the quality-adjusted years than without medications (QALY = .125). The proportion of individuals recommended to Level One at MHMRA is 56.5%. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

\[
100 \times 0.125 \times 0.565 \times \$50,000 = \$353,125
\]

**Level Two: Medication plus therapy**

About 18.5% of patients at MHMRA are recommended to Level Two services based on moderately severe need accompanied by diagnoses of major depression. This service package includes cognitive psychotherapy for depressive disorders in addition to medications. Pyne et al. (2003) compared the cost-effectiveness of medication services to medication plus CBT for depression. Their randomized controlled trial yielded an incremental QALY of 0.041 for the addition of CBT. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

\[
100 \times 0.041 \times 0.185 \times \$50,000 = \$37,925
\]

**Level Three: Medications and skills training**

About 24% of patients at MHMRA are recommended to Level Three services, based on higher severity symptom and functional skill impairment. This package includes medications and skills training. Barton and colleagues (2009) compared social recovery oriented cognitive
behavioral therapy (SRCBT) for people diagnosed with psychosis compared to case management alone (CMA); they reported a mean incremental QALY gain of 0.035. Assuming the program would serve 100 persons in a year; the following formula shows the valuation:

\[
\begin{align*}
100 & \text{ (persons served)} \\
0.035 & \text{ (QALY gained)} \\
0.24 & \text{ (proportion of patients recommended to Level 3)} \\
\times$50,000 & \text{ (life year value)} \\
= & \$42,000 \text{ Level 3 QALY Value}
\end{align*}
\]

*Level Four: Assertive Community Treatment (ACT) for Persons with Serious Mental Illness*

Of consumers referred for services, about 4.1% are recommended for ACT Team treatment. This level of care represents the highest intensity service intervention. A 2012 study reported the cost-effectiveness of assertive community treatment as part of integrated care versus standard care in patients with schizophrenia (Karow, Reimer, König, Heider, Bock & Huber 2012). Results indicated the ACT intervention yielded a QALY of 0.76, whereas the treatment as usual groups resulted in a QALY of 0.66. Since the treatment is being contrasted with wait list or not treatment, the full QALY (0.76) applies. The incremental QALY for the ACT group was 0.10. Assuming the program would serve 100 persons in a year the following formula shows the valuation:

\[
\begin{align*}
100 & \text{ (persons served)} \\
0.76 & \text{ (QALY gained)} \\
0.041 & \text{ Proportion of patients recommended to Level Four} \\
\times$50,000 & \text{ (life year value)} \\
= & \$155,800 \text{ Level 4 QALY Value}
\end{align*}
\]

**Hospitalizations**

When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 1.66 fewer public psychiatric hospital bed days per person. Cost savings from these individuals from averting hospital services can be calculated as follows:

\[
\begin{align*}
100 & \text{ (persons served)} \\
1.66 & \text{ (average hospital bed days per person per year averted)} \\
\times$700 & \text{ (cost of hospital day)} \\
= & \$116,200 \text{ Costs saved from averted hospitalizations}
\end{align*}
\]

**Public Psychiatric Emergency Visits**

When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.212 fewer public psychiatric emergency room visits per person. Cost savings from these individuals from averting these emergency services can be calculated as follows:

\[
\begin{align*}
100 & \text{ (persons served)} \\
0.212 & \text{ (average emergency service visits per person per year averted)} \\
\times & \text{ (cost per visit)} \\
= & \text{ Costs saved from averted emergency visits}
\end{align*}
\]
Mental Health Services in the County Jail
When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.05 fewer county jail incarcerations per person. Cost savings from averting these jail bookings can be calculated as follows:

\[
\begin{align*}
100 & \text{ (persons served)} \\
.05 & \text{ (average county jail incarcerations per person per year averted)} \\
40.6 & \text{ Average days incarcerated} \\
X$130 & \text{ (cost of jail day with mental health service)} \\
\end{align*}
\]

\[= $26,390 \text{ Costs saved from averted hospitalizations}\]

Valuation Summary: This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). Summing the estimated utilities of all four levels of care above, the expected value of this proposal is $746,386 per 100 people served per year.
<table>
<thead>
<tr>
<th>Unique Identifier:</th>
<th>RHP PP Reference Number:</th>
<th>Project Components:</th>
<th>Program Title: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - SW</th>
</tr>
</thead>
<tbody>
<tr>
<td>113180703.1.5</td>
<td>1.12.2</td>
<td>NA</td>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
</tr>
</tbody>
</table>

**Related Category 3 Measure(s):**
- Patient Satisfaction
- Functional Assessment

**Unique Category 3 Project ID:**
- 113180703.3.5
- 113180703.3.25

**IT**
- 6.1
- 10.1

**Percent improvement over baseline of patient satisfaction scores**

**Improvement in functional status**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1: P-2.** Identify licenses, equipment requirements and other components needed to implement and operate options selected.

**Metric 1: P-2.5.1** Develop a project plan and timeline detailing operational needs and equipment and components

**Data Source:** Written Project Plan

**Goal:** Complete project plan within timeline to start providing services in DY 3

**Estimated Incentive Payment:** $1,493,333.07

**Milestone 3: P-6:** Establish behavioral health services in new community-based settings in underserved areas

**Metric 1: P-6.1** Number of new community-based settings where behavioral health services are delivered

**Data Source:** Project documentation and MHMRA records

**Goal:** Serve at least 250 patients being served by new treatment team

**Estimated Incentive Payment:** $1,094,430.09

**Milestone 6: I-11:** Increased utilization of community behavioral healthcare

**Metric 1: I-11.1** Percent utilization of community behavioral healthcare services.

**Data Source:** MHMRA records

**Goal:** Serve 500 patients more than baseline

**Estimated Incentive Payment:** $1,754,273.38

**Milestone 8: I-11:** Increased utilization of community behavioral healthcare

**Metric 1: I-11.1** Percent utilization of community behavioral healthcare services.

**Data Source:** MHMRA records

**Goal:** Serve 500 patients more than baseline

**Estimated Incentive Payment:** $1,694,950.12
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 2: P-4:</strong> Hire and train staff to operate and manage project</td>
<td><strong>Milestone 4:</strong> I-11 Increased utilization of community behavioral healthcare</td>
<td><strong>Milestone 7:</strong> I-X. Reduction in Inpatient Psychiatric Admissions (HCPC)</td>
<td><strong>Milestone 9:</strong> I-X. Reduction in Inpatient Psychiatric Admissions (HCPC)</td>
</tr>
<tr>
<td><strong>Metric 1: P-4.1:</strong> Number of staff secured and trained</td>
<td><strong>Metric 1:</strong> I-11.1 Percent utilization of community behavioral healthcare services.</td>
<td><strong>Metric 1:</strong> I-X.1. Percent of individuals who were admitted to inpatient facilities. Denominator: Number of patients served by program Numerator: Number of patients served in OP clinic who admitted to HCPC</td>
<td><strong>Metric 1:</strong> I-X.1. Percent of individuals who were admitted to inpatient facilities. Denominator: Number of patients served by program Numerator: Number of patients served in OP clinic who admitted to HCPC</td>
</tr>
<tr>
<td><strong>Data Source:</strong> HR records</td>
<td><strong>Data Source:</strong> MHMRA records</td>
<td><strong>Data Source:</strong> MHMRA records and HCPC records</td>
<td><strong>Data Source:</strong> MHMRA records and HCPC records</td>
</tr>
<tr>
<td><strong>Goal:</strong> hire staff for one additional treatment team</td>
<td><strong>Goal:</strong> establish baseline</td>
<td><strong>Goal:</strong> A 5% decrease from baseline in HCPC admissions</td>
<td><strong>Goal:</strong> A 10% decrease from baseline in HCPC admissions</td>
</tr>
</tbody>
</table>

| Milestone 9: I-X. Reduction in Inpatient Psychiatric Admissions (HCPC) | **Metric 1:** I-X.1. Percent of individuals who were admitted to inpatient facilities. Denominator: Number of patients served by program Numerator: Number of patients served in OP clinic who admitted to HCPC | **Data Source:** MHMRA records and HCPC records | **Goal:** A 10% decrease from baseline in HCPC admissions |

<p>| <strong>Estimated Incentive Payment:</strong> $1,493,333.07 | <strong>Estimated Incentive Payment:</strong> $1,094,430.09 | <strong>Estimated Incentive Payment:</strong> $1,754,273.38 | <strong>Estimated Incentive Payment:</strong> $1,694,950.12 |</p>
<table>
<thead>
<tr>
<th>Related Category 3 Measure(s): Patient Satisfaction</th>
<th>Unique Category 3 Project ID:</th>
<th>IT-6.1</th>
<th>IT-10.1</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Assessment</td>
<td>113180703.3.5</td>
<td></td>
<td></td>
<td>Improvement in functional status</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 5:</strong> I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions</td>
<td><strong>Metric 1:</strong> I-X.1. Percent of individuals who were admitted to inpatient facilities.</td>
<td><strong>Data Source:</strong> Psychiatric Emergency Services (PES) records are part of the MHMRA electronic record. Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records</td>
<td><strong>Goal:</strong> Establish baseline</td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong></td>
<td><strong>Estimated Incentive Payment:</strong></td>
<td><strong>Estimated Incentive Payment:</strong></td>
<td><strong>Estimated Incentive Payment:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Milestone Bundle Amount:</strong> $2,986,666.15</td>
<td><strong>Year 3 Estimated Milestone Bundle Amount:</strong> $3,283,290.27</td>
<td><strong>Year 4 Estimated Milestone Bundle Amount:</strong> $3,508,546.76</td>
<td><strong>Year 5 Estimated Milestone Bundle Amount:</strong> $3,389,900.24</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $13,168,403.42
REFERENCES


1.12 Enhance service availability of appropriate level of behavioral health care: Expansion of outpatient behavioral health services for adults with severe psychiatric conditions (Southeast)

RHP Project Number: 113180703.1.6

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to increase outpatient capacity to potentially eliminate the current wait list for services in this geographic area. The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. In an effort to provide needed services to the most critically ill population, MHMRA proposes to increase outpatient capacity by approximately 500 individuals potentially eliminating the current wait list for services in this geographic area. In order to address this issue we will choose to focus on project option 1.12.2: Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

It is important to note that we are proposing four similar projects, each under the 1.12.2 umbrella, which would expand outpatient behavioral health services for adults in each of our existing clinics. Outpatient services for this program include psychopharmacological interventions, provision of psychiatric medications to the medically uninsured, case management, psychosocial skills training and psychotherapy, family therapy and linkages to needed resources in the community. Each of the expansion program serves unique geographical needs, and therefore, each of the projects are critical to addressing the community needs.

MHMRA of Harris County provides adult mental health outpatient services to patients with serious mental illness according to a utilization management scheme intended to provide the right level of service matching the assessed severity of need. The majority of patients (78%) receive Level One service. This mix of assessment, case management and psychiatric treatment averages 13.44 hours per patient per year. At Medicaid reimbursement rates, these services would be valued at $1,209 per patient per year. In addition, MHMRA provides medications to the medically indigent at a rate of $2036 per person per year. The combined value of staff services and medications is estimated at $3,255 per person per year for this (lowest) utilization management group. The Level Two package adds cognitive behavior therapy for major depression to the service mix. Although the package averages nearly three times the service
hours per person, the reimbursement rate is just slightly higher. Level Threes services include psychosocial skills training, doubling the hours of service over package Two, at a rate of $4,317 per person per year. Finally, Assertive Community Treatment (ACT) is the most intense and expensive package reserved for those most in need at an estimated cost/value of $6,975 per person.

### Per Person Per Year Estimates of Costs/Values of Services x Level of Care

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>Proportion</th>
<th>Annual # Services</th>
<th>Annual Hours of Service</th>
<th>Annual Value of Services*</th>
<th>Annual Value of Medications</th>
<th>Total Cost/Value of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level One</td>
<td></td>
<td>78%</td>
<td>39.08</td>
<td>13.44</td>
<td>$1,219</td>
<td>$2,036</td>
<td>$3,255</td>
</tr>
<tr>
<td>Level Two</td>
<td></td>
<td>9%</td>
<td>63.23</td>
<td>34.5</td>
<td>$1,244</td>
<td>$2,036</td>
<td>$3,280</td>
</tr>
<tr>
<td>Level Three</td>
<td></td>
<td>10%</td>
<td>131.28</td>
<td>68.05</td>
<td>$2,281</td>
<td>$2,036</td>
<td>$4,317</td>
</tr>
<tr>
<td>ACT</td>
<td></td>
<td>1%</td>
<td>387.53</td>
<td>187.86</td>
<td>$4,939</td>
<td>$2,036</td>
<td>$6,975</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>59.12</strong></td>
<td><strong>25.26</strong></td>
<td><strong>$1,428</strong></td>
<td><strong>$2,036</strong></td>
<td><strong>$3,464</strong></td>
<td></td>
</tr>
</tbody>
</table>

*2012 Medicaid Reimbursement Rates

### Starting Point/Baseline:
As mentioned previously, 8,800 consumers are served among the four existing outpatient clinics. By adding the five teams proposed under the five related projects, the total adult outpatient capacity would be expanded to 11,300 treatment slots. The current project will add 500 of the expansion slots by DY4 and continuing through DY5. Current clinical space will be used in addition to redesigning available MHMRA space or seeking additional space as needed to house additional staff over the DSRIP period.

### Rationale:
The community mental health system in Harris County has a limited capacity for service that is insufficient to the needs of its residents. The Mental Health Needs Council of Harris County has estimated that 153,000 of the 552,000 Harris County adults with mental illness have a severe mental illness (Depression, Bipolar Disorder, and Schizophrenia). These individuals are among the 96,200 Harris County adults who have no public (Medicaid or Medicare) or private health insurance and therefore, are totally dependent on the public mental health service system for treatment. In 2007, approximately 27,000 adults received services from the public mental health system; 18,200 of these were uninsured (a number representing only 19% of estimated need). By deduction, one can conclude that approximately 78,000 adults with severe mental illness failed to access treatment from the public or private mental health systems.

The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the waiting list for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service.

On August 31 (2012), the MHMRA waitlist for adult mental health outpatient services rested at 1,695, a level that has persisted for several years. Further, tenure on the waiting list
approached five months, an average of 149.16 days. The majority of consumers on the MHMRA waitlist (31.1%) reside in the Southeast section of town.

The rationale for requesting funding for each project is based on the aforementioned need for additional mental health services in the county, and the existing waitlist. If MHMRA were to expand only one or two of the clinics, only 400-800 new consumers could be served and the waitlist would remain in effect. Additionally, it is expected that the need for mental health services will continue to grow, and therefore, limited expansion will simply not address the current needs of those on the waitlist or the community needs of those who initiated services with MHMRA.

**Unique Community Need Identification numbers:**
Specific community needs are also addressed through the proposed program:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Expansion of outpatient behavioral health services will address the community needs above by providing greater access to behavioral health care, thereby offsetting the increased use of medical and psychiatric emergency services. Furthermore, a larger behavioral health workforce within MHMRA will provide more opportunities for collaboration between providers and for patient education. MHMRA clinicians already engage in a variety of community collaborations and education activities, despite their tremendous workload. With the addition of qualified behavioral health personnel, more services can be provided.

**Goals and Relationship to Regional Goals:**
Goals include improving access to community mental health services by establishing additional service providers (e.g., an additional treatment team) among existing MHMRA community clinics in Harris County. Specifically, we aspire to place one new treatment team in the Southeast region. Each treatment team can serve roughly 500 consumers.

The proposed project directly meets broad goals identified by the regional needs assessment. First, it improves and builds upon an existing program, which has shown positive gains in providing best-practices for patient-centered care. Furthermore, by providing enhanced, evidence-based services to patients the program will meet the regional goal set out above. Moreover, the program supports the regional goal of developing a culture of patient-centered care whereby the patient/consumer plays a more active role as a stakeholder.

**Challenges:**
Workforce limitations may provide staff recruitment challenges requiring significant lead time and advanced planning. Clinic managers will work closely with human resources and administration to ensure timely staffing of the proposed treatment teams.

**Expected 5-year Outcomes:**
13) Staffing of the new team: 1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, 12 Rehabilitation Clinicians, 1 Administrative Assistant, 1 Clerical Support Staff, 1 Business Office Coordinator, and 1 HIT Staff.
14) Additional need is anticipated as initiatives to reduce 30-day re-hospitalizations, preventable emergency department visits, and jail recidivism, may create additional demand.

15) Provision of outpatient mental health service has been locally documented to reduce emergency psychiatric center visits by .37 visits per person per year; it has also has been shown to reduce public psychiatric hospital use by 1.66 bed days per person per year in a sample of 25,000 outpatients (served between the years 2005 and 2012).

16) Elimination of wait lists and improved geographic access can be expected to increase access to services, improved satisfaction, and decreased intensive service use. Reductions in intensive service (#3 and #4 above) use are firmly in line with regional project goals.

We expect to create a static capacity to treat 100 by Year 2, 250 by Year 3, and 500 in both years 4 and 5. Since the average length of stay in outpatient services is less than one year (about 11 months) numbers served will exceed the estimates of created treatment slots. We expect these patients to experience positive results from receiving the proposed treatment interventions. Specifically, we expect patients will improve their functional status due to a reduction in psychiatric symptoms, resulting in fewer psychiatric emergencies. Furthermore, because MHMRA believes it is vital to engage patients in their treatment we expect that patients will report increased levels of communication and collaboration with treatment providers. Because of the anticipated impact on patients, we chose the related improvement goals: increased utilization of behavioral health (I-11.1) and decreased emergency psychiatric service use (I-X).

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

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

IT-10.1: Demonstrate improvement in functional status

**Reasons/rationale for selecting the outcome measures:**

We believe patient satisfaction that addresses patient involvement in shared decision making and collaborative care, will reduce chronic over-use of psychiatric emergency services and in general reduce cost and improve efficiency. By enhancing service availability of appropriate levels of outpatient behavioral health care we will address the community needs. Also providing greater access to behavioral health care and the addition of qualified behavioral health care professionals will allow for the provision of more services, great patient satisfaction and improved patient outcomes. We will be using the applicable parts of CAPHs to access this aspect of patient satisfaction and will be setting a target of 10% improvement in patient satisfaction by the end of Year 5.

**IT-10.1: Functional Status**

We believe that our identified objective of transforming the current health care delivery system will be directly impacted by improving patient functioning. This transformation is proposed to be a patient-centered, coordinated delivery model that improves patient outcomes
through better patient functioning. Based on this objective, the proposed program has identified the ANSA (Adult Needs and Strengths Assessment), as a targeted means to measure outcome improvement goals. ANSA is a comprehensive assessment and outcome tool that measures both patient strengths that can be used to build on for patient growth and also patients needs for purposes of treatment planning and delivery. We expect that by DY5 there will be a 10% increase on at least one of the domains measured by the ANSA for patients in the program.

Relationship to other Projects:

The proposed project is similar to several MHMRA DSRIP proposals, including the expansion of outpatient behavioral health services within other clinics (113180703.1.1, 113180703.1.4, 113180703.1.5 and 113180703.1.7). Extending outpatient behavioral health specialty service and increasing the intensity of these services will together ultimately provide responsive, appropriate levels of care.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Relationship to Other Performing Providers’ Projects in the RHP: TBD

Plan for Learning Collaborative:

Consumer satisfaction with access outcomes will be assessed with input from consumer groups involving both patients and family members in the quality improvement loop. Similarly, rates of public psychiatric hospitalization will be presented to public psychiatric hospital representatives with an invitation for them to provide input on the improvement process.

Project Valuation:

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

Cost-Utility Analysis: The Texas Recommended Assessment Guidelines (Texas Department of State Health Services, 2011) established a utilization management scheme for matching patient need to service packages of varying intensities. To provide an approximation of the value of an outpatient behavioral health program, we will review studies related to each of the four service packages described below as “levels of care.”

**Level One: Medication only**

Individuals receiving Service Package One (SP1) have been assessed to have relatively less severe symptomatology and functional impairment. Therefore, they receive medications only accompanied by service coordination. A study by Chouinard and Albright (1997) found that individuals receiving medications versus a placebo gained 7 times the quality-adjusted years than without medications (QALY = .125). The proportion of individuals recommended to Level One at MHMRA is 56.5%. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

\[
\begin{align*}
100 \text{ (persons served)} \\
0.125 \text{ (QALY gained)} \\
0.565 \text{ (proportion of patients recommended to Level One)} \times $50,000 \text{ (life year value)} \\
= $353,125 \text{ Level 1 QALY Value}
\end{align*}
\]

**Level Two: Medication plus therapy**

About 18.5% of patients at MHMRA are recommended to Level Two services based on moderately severe need accompanied by diagnoses of major depression. This service package includes cognitive psychotherapy for depressive disorders in addition to medications. Pyne et al. (2003) compared the cost-effectiveness of medication services to medication plus CBT for depression. Their randomized controlled trial yielded an incremental QALY of 0.041 for the addition of CBT. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

\[
\begin{align*}
100 \text{ (persons served)} \\
0.041 \text{ (QALY gained)} \\
0.185 \text{ (proportion of patients recommended to Level 2)} \times $50,000 \text{ (life year value)} \\
= $37,925 \text{ Level 2 QALY Valuation}
\end{align*}
\]

**Level Three: Medications and skills training**

About 24% of patients at MHMRA are recommended to Level Three services, based on higher severity symptom and functional skill impairment. This package includes medications and skills training. Barton and colleagues (2009) compared social recovery oriented cognitive
behavioral therapy (SRCBT) for people diagnosed with psychosis compared to case management alone (CMA); they reported a mean incremental QALY gain of 0.035. Assuming the program would serve 100 persons in a year; the following formula shows the valuation:

\[
\begin{align*}
100 \text{ (persons served)} & \\
0.035 \text{ (QALY gained)} & \\
0.24 \text{ (proportion of patients recommended to Level 3)} & \\
\times $50,000 \text{ (life year value)} & \\
= $42,000 \text{ Level 3 QALY Value} & \\
\end{align*}
\]

\textit{Level Four: Assertive Community Treatment (ACT) for Persons with Serious Mental Illness}

Of consumers referred for services, about 4.1% are recommended for ACT Team treatment. This level of care represents the highest intensity service intervention. A 2012 study reported the cost-effectiveness of assertive community treatment as part of integrated care versus standard care in patients with schizophrenia (Karow, Reimer, König, Heider, Bock & Huber 2012). Results indicated the ACT intervention yielded a QALY of 0.76, whereas the treatment as usual groups resulted in a QALY of 0.66. Since the treatment is being contrasted with wait list or not treatment, the full QALY (0.76) applies. The incremental QALY for the ACT group was 0.10. Assuming the program would serve 100 persons in a year the following formula shows the valuation:

\[
\begin{align*}
100 \text{ (persons served)} & \\
0.76 \text{ (QALY gained)} & \\
0.041 \text{ Proportion of patients recommended to Level Four} & \\
\times $50,000 \text{ (life year value)} & \\
= $155,800 \text{ Level 4 QALY Value} & \\
\end{align*}
\]

\textbf{Hospitalizations}

When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 1.66 fewer public psychiatric hospital bed days per person. Cost savings from these individuals from averting hospital services can be calculated as follows:

\[
\begin{align*}
100 \text{ (persons served)} & \\
1.66 \text{ (average hospital bed days per person per year averted)} & \\
\times $700 \text{ (cost of hospital day)} & \\
= $116,200 \text{ Costs saved from averted hospitalizations} & \\
\end{align*}
\]

\textbf{Public Psychiatric Emergency Visits}

When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.212 fewer public psychiatric emergency room visits per person. Cost savings from these individuals from averting these emergency services can be calculated as follows:

\[
\begin{align*}
100 \text{ (persons served)} & \\
.212 \text{ (average emergency service visits per person per year averted)} & \\
\times $700 \text{ (cost of hospital day)} & \\
= $116,200 \text{ Costs saved from averted hospitalizations} & \\
\end{align*}
\]
X$705 (cost of hospital day)  
= $14,946 Costs saved from averted hospitalizations

**Mental Health Services in the County Jail**
When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.05 fewer county jail incarcerations per person. Cost savings from averting these jail bookings can be calculated as follows:

\[
\begin{align*}
100 \text{ (persons served)} \\
0.05 \text{ (average county jail incarcerations per person per year averted)} \\
40.6 \text{ Average days incarcerated} \\
X$130 \text{ (cost of jail day with mental health service)} \\
= $26,390 \text{ Costs saved from averted hospitalizations}
\end{align*}
\]

**Valuation Summary**: This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). Summing the estimated utilities of all four levels of care above, the expected value of this proposal is $746,386 per 100 people served per year.
**Program Title:** EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - SE

**RHP Performing Provider:** Mental Health and Mental Retardation Authority of Harris County

**TPI:** 113180703

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1:** P-2. Identify licenses, equipment requirements and other components needed to implement and operate options selected.

**Metric 1:** P-2.5.1 Develop a project plan and timeline detailing operational needs and equipment and components

**Data Source:** Written Project Plan

**Goal:** Complete project plan within timeline to start providing services in DY 3

**Milestone 3:** P-6: Establish behavioral health services in new community-based settings in underserved areas

**Metric 1:** P-6.1 Number of new community-based settings where behavioral health services are delivered

**Data Source:** Project documentation and MHMRA records

**Goal:** Provide documentation of at least 250 patients being served by new treatment team

**Milestone 6:** I-11: Increased utilization of community behavioral healthcare

**Metric 1:** I-11.1 Percent utilization of community behavioral healthcare services.

**Data Source:** MHMRA records

**Goal:** Serve 500 patients more than baseline

**Estimated Incentive Payment:** $1,493,333.07

**Estimated Incentive Payment:** $1,094,430.09

**Estimated Incentive Payment:** $1,754,273.38

**Estimated Incentive Payment:** $1,694,950.12
<table>
<thead>
<tr>
<th>Unique Identifier: 113180703.1.6</th>
<th>RHP PP Reference Number: 1.12.2</th>
<th>Project Components: NA</th>
<th>Program Title: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td>TPI: 113180703</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Measure(s): Patient Satisfaction Functional Assessment</td>
<td>Unique Category 3 Project ID: 113180703.3.6 113180703.3.26</td>
<td>IT-6.1 IT-10.1</td>
<td>Percent improvement over baseline of patient satisfaction scores Improvement in functional status</td>
</tr>
<tr>
<td>Year 2  (10/1/2012 – 9/30/2013)</td>
<td>Year 3  (10/1/2013 – 9/30/2014)</td>
<td>Year 4  (10/1/2014 – 9/30/2015)</td>
<td>Year 5  (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Milestone 2: P-4:</strong> Hire and train staff to operate and manage project  <strong>Metric 1: P-4.1:</strong> Number of staff secured and trained  <strong>Data Source:</strong> HR records  <strong>Goal:</strong> hire staff for one additional treatment team</td>
<td><strong>Milestone 4: I-11 Increased utilization of community behavioral healthcare  Metric 1: I-11.1 Percent utilization of community behavioral healthcare services.  Data Source: MHMRA records  Goal: establish baseline</strong></td>
<td><strong>Milestone 7: I-X. Reduction in Inpatient Psychiatric Admissions (HCPC)  Metric 1: I-X.1. Percent of individuals who were admitted to inpatient facilities.  Denominator: Number of patients served by program  Numerator: Number of patients served in OP clinic who admitted to HCPC  Data Source: MHMRA and HCPC records  Goal: A 5% decrease from baseline in HCPC admissions</strong></td>
<td><strong>Milestone 9: I-X. Reduction in Inpatient Psychiatric Admissions (HCPC)  Metric 1: I-X.1. Percent of individuals who were admitted to inpatient facilities.  Denominator: Number of patients served by program  Numerator: Number of patients served in OP clinic who admitted to HCPC  Data Source: MHMRA and HCPC records  Goal: A 10% decrease from baseline in HCPC admissions</strong></td>
</tr>
<tr>
<td>Estimated Incentive Payment: $1,493,333.07</td>
<td>Estimated Incentive Payment: $1,094,430.09</td>
<td>Estimated Incentive Payment: $1,754,273.38</td>
<td>Estimated Incentive Payment: $1,694,950.12</td>
</tr>
<tr>
<td> </td>
<td>Unique Identifier: 113180703.1.6</td>
<td>RHP PP Reference Number: 1.12.2</td>
<td>Project Components: NA</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td></td>
<td></td>
<td>TPI: 113180703</td>
</tr>
<tr>
<td>Related Category 3 Measure(s):</td>
<td>Unique Category 3 Project ID:</td>
<td>IT-6.1</td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>113180703.3.6</td>
<td>IT-10.1</td>
<td>Improvement in functional status</td>
</tr>
<tr>
<td>Functional Assessment</td>
<td>113180703.3.26</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 5</strong>: I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions**</td>
<td><strong>Metric 1</strong>: I-X.1. Percent of individuals who were admitted to inpatient facilities. <strong>Data Source</strong>: Psychiatric Emergency Services (PES) records are part of the MHMRA electronic record. Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records. <strong>Goal</strong>: Establish baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment</strong>: $1,094,430.09</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Year 2 Estimated Milestone Bundle Amount: $2,986,666.15 | Year 3 Estimated Milestone Bundle Amount: $3,283,290.27 | Year 4 Estimated Milestone Bundle Amount: $3,508,546.76 | Year 5 Estimated Milestone Bundle Amount: $3,389,900.24 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $13,168,403.42**
REFERENCES


1.12 Enhance service availability of appropriate level of behavioral health care: Expansion of outpatient behavioral health services for adults with severe psychiatric conditions (TBD)

**RHP Project Number:** 113180703.1.7

**Performing Provider/TPI:** Mental Health and Mental Retardation Authority of Harris County/ 113180703

**Project Description:**

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to increase outpatient capacity to potentially eliminate the current wait list for services in this geographic area.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. In an effort to provide needed services to the most critically ill population, MHMRA proposes to increase outpatient capacity by approximately 500 individuals potentially eliminating the current wait list for services in this geographic area. In order to address this issue we will choose to focus on project option 1.12.2: Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

It is important to note that we are proposing four similar projects, each under the 1.12.2 umbrella, which would expand outpatient behavioral health services for adults in each of our existing clinics. Outpatient services for this program include psychopharmacological interventions, provision of psychiatric medications to the medically uninsured, case management, psychosocial skills training and psychotherapy, family therapy and linkages to needed resources in the community. Each of the expansion programs serves unique geographical needs, and therefore, all of the projects are critical to addressing the community needs.

MHMRA of Harris County provides adult mental health outpatient services to patients with serious mental illness according to a utilization management scheme intended to provide the right level of service matching the assessed severity of need. The majority of patients (78%) receive Level One service. This mix of assessment, case management and psychiatric treatment averages 13.44 hours per patient per year. At Medicaid reimbursement rates, these services would be valued at $1,209 per patient per year. In addition, MHMRA provides medications to the medically indigent at a rate of $2036 per person per year. The combined value of staff services and medications is estimated at $3,255 per person per year for this (lowest) utilization management group. The Level Two package adds cognitive behavior therapy for major depression to the service mix. Although the package averages nearly three times the service hours per person, the reimbursement rate is just slightly higher. Level Three services include psychosocial skills training, doubling the hours of service over package Two, at a rate of $4,317...
per person per year. Finally, Assertive Community Treatment (ACT) is the most intense and expensive package reserved for those most in need at an estimated cost/value of $6,975 per person. Table 1 summarizes MHMRA’s four levels of service and their associated costs.

Table 1. Per Person Per Year Estimates of Costs/Values of Services x Level of Care

<table>
<thead>
<tr>
<th>2012</th>
<th>Proportion of Patients</th>
<th>Annual # Services per Patient</th>
<th>Annual Hours of Service per Patient</th>
<th>Annual Value of Services*</th>
<th>Annual Value of Medications</th>
<th>Total Cost/Value of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level One</td>
<td>78%</td>
<td>39.08</td>
<td>13.44</td>
<td>$1,219</td>
<td>$2,036</td>
<td>$3,255</td>
</tr>
<tr>
<td>Level Two</td>
<td>9%</td>
<td>63.23</td>
<td>34.5</td>
<td>$1,244</td>
<td>$2,036</td>
<td>$3,280</td>
</tr>
<tr>
<td>Level Three</td>
<td>10%</td>
<td>131.28</td>
<td>68.05</td>
<td>$2,281</td>
<td>$2,036</td>
<td>$4,317</td>
</tr>
<tr>
<td>ACT</td>
<td>1%</td>
<td>387.53</td>
<td>187.86</td>
<td>$4,939</td>
<td>$2,036</td>
<td>$6,975</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>59.12</td>
<td>25.26</td>
<td>$1,428</td>
<td>$2,036</td>
<td>$3,464</td>
</tr>
</tbody>
</table>

*2012 Medicaid Reimbursement Rates

Goals and Relationship to Regional Goals:
Our goal is to improve access to community mental health services by establishing additional service providers (e.g., an additional treatment team) among existing MHMRA community clinics in Harris County. Specifically, we aspire to place one new treatment team in a region to be determined based on need. Each treatment team can serve roughly 500 consumers. The proposed project directly meets broad goals identified by the regional needs assessment. First, it improves and builds upon an existing program, which has shown positive gains in providing best-practices for patient-centered care. Furthermore, by providing enhanced, evidence-based services to patients the program will meet the regional goal set out above. Moreover, the program supports the regional goal of developing a culture of patient-centered care whereby the patient/consumer plays a more active role as a stakeholder.

Challenges:
Workforce limitations may provide staff recruitment challenges requiring significant lead time and advanced planning. Specifically, there are limitations on recruiting qualified professional psychiatrists, nursing staff, and psychologists. Clinic managers will work closely with human resources and administration to ensure timely staffing of the proposed treatment teams.

Expected 5-year Outcomes:
17) Staffing of the new team:
   a. 1 Psychiatrist
   b. 1 Nurse
   c. 1 Clinical Team Leader
   d. 4 Licensed Practitioners of the Healing Arts
   e. 12 Rehabilitation Clinicians
   f. 1 Administrative Assistant
   g. 1 Clerical Support Staff
   h. 1 Business Office Coordinator
   i. 1 HIT Staff
18) Additional need is anticipated as initiatives to reduce 30-day re-hospitalizations, preventable emergency department visits, and jail recidivism, may create additional demand.

19) Provision of outpatient mental health service has been locally documented to reduce emergency psychiatric center visits by .37 visits per person per year; it has also has been shown to reduce public psychiatric hospital use by 1.66 bed days per person per year in a sample of 25,000 outpatients (served between the years 2005 and 2012).

20) Elimination of wait lists and improved geographic access can be expected to increase access to services, improved satisfaction, and decreased intensive service use.

Reductions in intensive service (#3 and #4 above) use are firmly in line with regional project goals.

In order to measure the progress toward the stated goals, we have selected improvement metrics that measure increased utilization of behavioral health (I-11.1) and decreased emergency psychiatric service use (I-X).

We expect create static capacity to treat 100 by Year 2, 250 by Year 3, and 500 in both years 4 and 5. Since the average length of stay in outpatient services is less than one year (about 11 months) numbers served will exceed the estimates of created treatment slots. We expect these patients to experience positive results from receiving the proposed treatment interventions. Specifically, we expect patients will improve their functional status due to a reduction in psychiatric symptoms. Furthermore, because MHMRA believes it is vital to engage patients in their treatment we expect that patients will report increased levels of communication and collaboration with treatment providers.

Starting Point/Baseline:
As mentioned previously, the four existing outpatient clinics currently serve 8,800 consumers. By adding the five teams proposed under the five related projects, the total adult outpatient capacity would be expanded to 11,300 treatment slots. The current project will add 500 of the expansion slots by DY4 and continuing through DY5. Current clinical space will be used in addition to redesigning available MHMRA space or seeking additional space as needed to house additional staff over the DSRIP period.

Rationale:
The community mental health system in Harris County has a limited capacity for service that is insufficient for meeting the needs of its residents. The Mental Health Needs Council of Harris County has estimated that 153,000 of the 552,000 Harris County adults with mental illness have a severe mental illness (depression, bipolar disorder, and schizophrenia). These individuals are among the 96,200 Harris County adults who have no public (Medicaid or Medicare) or private health insurance and, therefore, are totally dependent on the public mental health service system for treatment. In 2007, approximately 27,000 adults received services from the public mental health system; 18,200 of these were uninsured (a number representing only 19% of estimated need). By deduction, one can conclude that approximately 78,000 adults with severe mental illness failed to access treatment from the public or private mental health systems.

The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the waiting list for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service
capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service.

As of August 31, 2012, the MHMRA waitlist for adult mental health outpatient services consisted of 1,695 individuals – a level that has persisted for several years. Further, tenure on the waiting list approached five months, an average of about 149 days. The clinic will be placed in the area of town where the greatest need is determined to be.

The rationale for requesting funding for each project is based on the aforementioned need for additional mental health services in the county, and the existing waitlist. If MHMRA were to expand only one or two of the clinics, only 400-800 new consumers could be served and the waitlist would remain in effect. Additionally, it is expected that the need for mental health services will continue to grow, and therefore, limited expansion will simply not address the current needs of those on the waitlist or the community needs of those who initiated services with MHMRA.

**Unique Community Need Identification numbers:**
Specific community needs are also addressed through the proposed program:
- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Expansion of outpatient behavioral health services will address the community needs above by providing greater access to behavioral health care, thereby offsetting the increased use of medical and psychiatric emergency services. Furthermore, a larger behavioral health workforce within MHMRA will provide more opportunities for collaboration between providers and for patient education. MHMRA clinicians already engage in a variety of community collaborations and education activities, despite their tremendous workload. With the addition of qualified behavioral health personnel, more services can be provided.

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

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

**Reasons/rationale for selecting the outcome measures:**

We believe patient satisfaction related to shared decision making and collaborative care, will reduce preventable admissions or readmissions to psychiatric emergency services and, in general, reduce cost and improve efficiency. By enhancing service availability of appropriate levels of outpatient behavioral health care we will address the community needs. Also, providing greater access to behavioral health care through the addition of qualified behavioral health care professionals will allow for the provision of more services, great patient satisfaction and improved patient outcomes. We will be using the applicable parts of CAPHS to access this aspect of patient satisfaction and will be setting a target of 10% improvement in patient satisfaction by the end of Year 5.

**IT-10.1: Functional Status**
We believe that our identified objective of transforming the current health care delivery system will be directly impacted by improving patient functioning. This transformation is proposed to be a patient-centered, coordinated delivery model that improves patient outcomes through better patient functioning. Based on this objective, the proposed program has identified the Adult Needs and Strengths Assessment (ANSA), as an instrument to measure outcome improvement goals. ANSA is a comprehensive assessment and outcome tool that measures patient strengths that can be used to build on for patient growth and also patient needs for purposes of treatment planning and delivery. We expect that by DY5 there will be a 10% increase on at least one of the domains measured by the ANSA for patients in the program.

**Relationship to other Projects:**

The proposed project is similar to several MHMRA DSIRIP proposals, including the expansion of outpatient behavioral health services within other clinics (113180703.1.1, 113180703.1.4, 113180703.1.5 and 113180703.1.6. Extending outpatient behavioral health specialty service and increasing the intensity of these services will together ultimately provide responsive, appropriate levels of care.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

**Relationship to Other Performing Providers’ Projects in the RHP:**  TBD

**Plan for Learning Collaborative:**

Consumer satisfaction with access outcomes will be assessed with input from consumer groups involving both patients and family members in the quality improvement loop. Similarly, rates of public psychiatric hospitalization will be presented to public psychiatric hospital representatives with an invitation for them to provide input on the improvement process.

**Project Valuation:**

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions the common health goal, or outcome, is the number of life-years added. The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature.

Cost-Utility Analysis: The Texas Recommended Assessment Guidelines (Texas Department of State Health Services, 2011) established a utilization management scheme for matching patient need to service packages of varying intensities. To provide an approximation of the value of an outpatient behavioral health program, we will review studies related to each of the four service packages described below as “levels of care.”

Level One: Medication only

Individuals receiving Service Package One (SP1) have been assessed to have relatively less severe symptomatology and functional impairment. Therefore, they receive medications only accompanied by service coordination. A study by Chouinard and Albright (1997) found that individuals receiving medications versus a placebo gained 7 times the quality-adjusted years than without medications (QALY = .125). The proportion of individuals recommended to Level One at MHMRA is 56.5%. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

\[
\text{QALY Value} = \frac{100}{\text{persons served}} \times \frac{0.125}{\text{QALY gained}} \times \frac{.565}{\text{proportion of patients recommended to Level One}} \times \frac{.50,000}{\text{life year value}} = \$353,125
\]

Level Two: Medication plus therapy

About 18.5% of patients at MHMRA are recommended to Level Two services based on moderately severe need accompanied by diagnoses of major depression. This service package includes cognitive psychotherapy for depressive disorders in addition to medications. Pyne et al. (2003) compared the cost-effectiveness of medication services to medication plus CBT for depression. Their randomized controlled trial yielded an incremental QALY of 0.041 for the addition of CBT. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

\[
\text{QALY Valuation} = \frac{100}{\text{persons served}} \times \frac{0.041}{\text{QALY gained}} \times \frac{.185}{\text{proportion of patients recommended to Level 2}} \times \frac{.50,000}{\text{life year value}} = \$37,925
\]

Level Three: Medications and skills training

About 24% of patients at MHMRA are recommended to Level Three services, based on higher severity symptom and functional skill impairment. This package includes medications and skills training. Barton and colleagues (2009) compared social recovery oriented cognitive
behavioral therapy (SRCBT) for people diagnosed with psychosis compared to case management alone (CMA); they reported a mean incremental QALY gain of 0.035. Assuming the program would serve 100 persons in a year; the following formula shows the valuation:

100  \( \text{persons served} \)  
0.035  \( \text{QALY gained} \)  
0.24  \( \text{proportion of patients recommended to Level 3} \)  
\( \times \) $50,000  \( \text{(life year value)} \)  
\( = \) $42,000  \( \text{Level 3 QALY Value} \)

**Level Four: Assertive Community Treatment (ACT) for Persons with Serious Mental Illness**

Of consumers referred for services, about 4.1% are recommended for ACT Team treatment. This level of care represents the highest intensity service intervention. A 2012 study reported the cost-effectiveness of assertive community treatment as part of integrated care versus standard care in patients with schizophrenia (Karow, Reimer, König, Heider, Bock & Huber 2012). Results indicated the ACT intervention yielded a QALY of 0.76, whereas the treatment as usual groups resulted in a QALY of 0.66. Since the treatment is being contrasted with wait list or not treatment, the full QALY (0.76) applies. The incremental QALY for the ACT group was 0.10. Assuming the program would serve 100 persons in a year the following formula shows the valuation:

100  \( \text{persons served} \)  
0.76  \( \text{QALY gained} \)  
0.041  \( \text{Proportion of patients recommended to Level Four} \)  
\( \times \) $50,000  \( \text{(life year value)} \)  
\( = \) $155,800  \( \text{Level 4 QALY Value} \)

**Hospitalizations**

When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 1.66 fewer public psychiatric hospital bed days per person. Cost savings from these individuals from averting hospital services can be calculated as follows:

100  \( \text{persons served} \)  
1.66  \( \text{average hospital bed days per person per year averted} \)  
\( \times \) $700  \( \text{(cost of hospital day)} \)  
\( = \) $116,200  \( \text{Costs saved from averted hospitalizations} \)

**Public Psychiatric Emergency Visits**

When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.212 fewer public psychiatric emergency room visits per person. Cost savings from these individuals from averting these emergency services can be calculated as follows:

100  \( \text{persons served} \)  
.212  \( \text{average emergency service visits per person per year averted} \)  
\( \times \) $705  \( \text{(cost of hospital day)} \)  
\( = \) $14,946  \( \text{Costs saved from averted hospitalizations} \)

**Mental Health Services in the County Jail**
When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.05 fewer county jail incarcerations per person. Cost savings from averting these jail bookings can be calculated as follows:

\[
\begin{align*}
\text{100} & \quad \text{(persons served)} \\
\text{.05} & \quad \text{(average county jail incarcerations per person per year averted)} \\
\text{40.6} & \quad \text{Average days incarcerated} \\
\times \text{130} & \quad \text{(cost of jail day with mental health service)} \\
= \text{26,390} & \quad \text{Costs saved from averted hospitalizations}
\end{align*}
\]

**Valuation Summary**: This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). Summing the estimated utilities of all four levels of care above, the expected value of this proposal is $746,386 per 100 people served per year.
<table>
<thead>
<tr>
<th>Related Category 3 Measure(s):</th>
<th>Unique Category 3 Project ID:</th>
<th>IT-6.1</th>
<th>IT-10.1</th>
<th>TPI: 113180703</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction</td>
<td>IT-6.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional Status</td>
<td>IT-10.1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Program Title:** EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - NE

**RHP Performing Provider:** Mental Health and Mental Retardation Authority of Harris County

**Unique Identifier:** 113180703.1.7

**RHP PP Reference Number:** 1.12.2

**Project Components:** NA

---

**Year 2**

*(10/1/2012 – 9/30/2013)*

**Milestone 1: P-2.** Identify licenses, equipment requirements and other components needed to implement and operate options selected.

**Metric 1: P-2.5.1** Develop a project plan and timeline detailing operational needs and equipment and components

**Data Source:** Written Project Plan

**Goal:** Complete project plan within timeline to start providing services in DY 3

---

**Year 3**

*(10/1/2013 – 9/30/2014)*

**Milestone 3: P-6:*** Establish behavioral health services in new community-based settings in underserved areas

**Metric 1: P-6.1** Number of new community-based settings where behavioral health services are delivered

**Data Source:** Project documentation and MHMRA records

**Goal:** Provide documentation of at least 250 patients being served by new treatment team

---

**Year 4**

*(10/1/2014 – 9/30/2015)*

**Milestone 6: I-11:** Increased utilization of community behavioral healthcare

**Metric 1: I-11.1** Percent utilization of community behavioral healthcare services.

**Data Source:** MHMRA records

**Goal:** Serve 500 patients more than baseline

---

**Year 5**

*(10/1/2015 – 9/30/2016)*

**Milestone 8: I-11:** Increased utilization of community behavioral healthcare

**Metric 1: I-11.1** Percent utilization of community behavioral healthcare services.

**Data Source:** MHMRA records

**Goal:** Serve 500 patients more than baseline

---

**Estimated Incentive Payment:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,493,333.07</td>
<td>$1,094,430.09</td>
<td>$1,754,273.38</td>
<td>$1,694,950.12</td>
</tr>
</tbody>
</table>

**Milestone 2: P-4:*** Hire and train staff to operate and manage project

**Metric 1: P-4.1:** Number of staff secured and trained

**Data Source:** HR records

**Goal:** Hire staff for one additional treatment team

---

**Estimated Incentive Payment:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,493,333.07</td>
<td>$1,094,430.09</td>
<td>$1,754,273.38</td>
<td>$1,694,950.12</td>
</tr>
</tbody>
</table>

**Milestone 4: I-11 Increased utilization of community behavioral healthcare

**Metric 1: I-11.1** Percent utilization of community behavioral healthcare services.

**Data Source:** MHMRA records

**Goal:** Establish baseline

---

**Estimated Incentive Payment:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,493,333.07</td>
<td>$1,094,430.09</td>
<td>$1,754,273.38</td>
<td>$1,694,950.12</td>
</tr>
</tbody>
</table>

**Milestone 7: I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions

**Metric 1: I-X.1** Percent of individuals who were admitted to inpatient facilities.

**Data Source:** MHMRA and HCPC records

**Goal:** A 5% decrease from baseline in PES/HCPC admissions

---

**Estimated Incentive Payment:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,493,333.07</td>
<td>$1,094,430.09</td>
<td>$1,754,273.38</td>
<td>$1,694,950.12</td>
</tr>
</tbody>
</table>


**Metric 1: I-X.1** Percent of individuals who were admitted to inpatient facilities.

**Data Source:** MHMRA and HCPC records

**Goal:** A 10% decrease from baseline in PES/HCPC admissions

---

**Estimated Incentive Payment:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,493,333.07</td>
<td>$1,094,430.09</td>
<td>$1,754,273.38</td>
<td>$1,694,950.12</td>
</tr>
<tr>
<td>Year</td>
<td>Measure</td>
<td>RHP PP Reference Number: 1.12.2</td>
<td>Unique Category 3 Project ID: 113180703.3.7</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td>TPI: 113180703</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Program Title: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - NE</td>
<td>Program Title: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - NE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Related Category 3 Measure(s): Patient Satisfaction Functional Status</td>
<td>Related Category 3 Measure(s): Patient Satisfaction Functional Status</td>
</tr>
<tr>
<td>Year 2</td>
<td>Milestone 5: I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions</td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
<td>Improvement in functional status</td>
</tr>
<tr>
<td>Year 4</td>
<td>Metric 1: I-X.1. Percent of individuals who were admitted to inpatient facilities.</td>
<td>Data Source: Psychiatric Emergency Services (PES) records are part of the MHMRA electronic record. Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records</td>
<td>Goal: Establish baseline</td>
</tr>
<tr>
<td>Year 5</td>
<td>Milestone 5: I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions</td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
<td>Improvement in functional status</td>
</tr>
<tr>
<td></td>
<td>Estimated Incentive Payment: $1,094,430.09</td>
<td>Estimated Incentive Payment: $1,094,430.09</td>
<td>Estimated Incentive Payment: $1,094,430.09</td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $2,986,666.15</td>
<td>Year 3 Estimated Milestone Bundle Amount: $3,283,290.27</td>
<td>Year 4 Estimated Milestone Bundle Amount: $3,508,546.76</td>
<td>Year 5 Estimated Milestone Bundle Amount: $3,389,900.24</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $13,168,403.42
REFERENCES


1.13 Development of Behavioral Health Crisis Stabilization Services as Alternatives to Hospitalization: Crisis Residential Unit (Cru)

Unique RHP Project Identification Number: 113180703.1.11

Performing Provider Name/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

PROJECT DESCRIPTION

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to Develop a behavioral health crisis stabilization service as an alternative to Hospitalization.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

For this project, MHMRA seeks to expand the Crisis Residential Unit (CRU). This 24-bed unit is specifically designed as a step-down from hospitalization with the goals of reducing the number of bed days required for acute psychiatric hospitalization, reducing hospitalization re-admission rates, and increasing tenure in the community and utilization of outpatient treatment alternatives.

Upon successful completion of the program, all residents will be eligible for an after-care program offering two (or more, as needed) weekly aftercare groups that are open to clients and their family members. The groups will be facilitated by a clinician and an alumnus/peer support staff member. The aftercare program will also offer an array of alumni services, including care coordination assistance, access to brief, solution-focused therapy, the opportunity to attend groups in the step-down unit, and group activities (e.g., outings, speakers, especially in the area of vocational opportunities). Furthermore, holiday activities and meals provide opportunities for building support networks, sharing resources, and creating a sense of community.

Goals and Relationship to Regional Goals: The goal of the program is to assist clients in developing skills to avoid future psychiatric crises. The program will be group-driven and will provide at least two individual therapy sessions per week. The program will utilize cognitive behavioral therapy (an evidence-based practice) as the focal intervention. Symptom management, problem solving, and coping skills will be central to the model; peer support groups will also be offered.

The five-year expected outcome(s): The five-year expected outcome is a reduction in the need to expand inpatient hospital capacity and consistent linkage of those served into ongoing
outpatient treatment programs. We expect that we will be fully operational to serve 321 patients in DY4 and DY5.

**Expected Number of Patients Served**

<table>
<thead>
<tr>
<th></th>
<th>DY 2</th>
<th>DY 3</th>
<th>DY 4</th>
<th>DY 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Served</td>
<td>0</td>
<td>0</td>
<td>321</td>
<td>321</td>
</tr>
</tbody>
</table>

**Rationale:** While MHMRA has implemented several crisis alternatives, there still exists a need to address individuals who may no longer be acutely ill, but are still very fragile and/or have a history of frequent hospital readmissions. A step-down residential program of intensive psychosocial treatment coupled with peer supports and after-care options is expected to help those individuals transition more successfully into ongoing treatment options.

**Baseline:** MHMRA does not currently have enough beds in the existing CRU to provide the proposed intervention; therefore, the first priority is to establish a new facility location. The bed capacity at the new location will be 24 beds, with the expectation that the program will be able to serve approximately 320 individuals per year.

**Anticipated challenges:** Challenges to implementation include locating and/or renovating appropriate program space and establishing appropriate linkage to ongoing service providers. These challenges will be addressed through stakeholder meetings including supportive housing providers, and through expansion of outpatient behavioral health services for adults with severe psychiatric conditions.

**Regional goals:** This project directly meets broad goals identified by the regional needs assessment. First, it improves on existing programs and infrastructure by developing a CRU specific to patients who would benefit from an intensive step-down program. Second, it increases access to specialty care services by providing treatment in a second location in the Houston area. This program is also an inherently patient-centered approach that provides transitional housing and residential care while linking patients to supportive community resources. The proposed program will also complement the regional need to develop a culture of “best practices” whereby the patient/consumer plays a more active role as a stakeholder by completing consumer satisfaction surveys.

**Community Need Identification numbers:** CRU addresses the following community needs:
This project was chosen with the expectation that community needs and regional goals would be met. The metrics chosen to assess the progress of the program focus on the reduction of readmissions services (I-X.1 Percent decrease in hospitalizations), reduction in ER services (I-X.1 Percent decrease in ER services) and reduction in Jail Bookings (10.1 Percent decrease from baseline in county jail bookings).

**Relationship to other Projects:** The proposed project is similar to several MHMRA DSRIP proposals, including the expansion of the Interim Care Clinic, the expansion of the Chronic Consumer Stabilization Initiative, and the redesign of the transition from HCPC hospitalization to MHMRA outpatient aftercare. All three proposals seek to expand psychiatric stabilization while reducing inpatient admissions and criminal justice involvement. It is hoped that many of the CRU patients could access these less restrictive and more appropriate care levels in lieu of hospitalization. Also, this project will interface with the expansion of outpatient mental health clinic services, the collaborative primary medical and behavioral health care, and with integrating substance abuse treatment services into mental health services by referring individuals into the appropriate ongoing care alternative.

**Unique community need identification number the project addresses:** This project will meet broad goals identified by the regional needs assessment. First, it improves on existing programs and infrastructure by filling a void that is unmet by existing psychiatric outpatient clinics and psychiatric emergency services. Second, it increases access to specialty care services by providing these services to a disenfranchised population. The program also offers a preventative, patient-centered approach that provides short-term mental health treatment to those without other resources. By providing such services, the program addresses the community problem of increased demand on criminal justice system. The proposed program will also complement the regional need to develop a culture of “best practices,” whereby the patient plays a more active role as a stakeholder by completing patient satisfaction surveys. The program is expected to reduce the re-incarceration rates of individuals who complete it and is also expected to improve the general functional well-being of its residents (as reflected in ANSA scores) so that they are better able to cope with the stressors of life after discharge.

The proposed program will address the following community needs:

- CN2-Insufficient Access to Behavioral Health
- CN5- Integrated Care for Behavioral Health
- CN12- Improved Access to Patient Education
- CN13- Services for Homeless
- CN14-Reduction of ER Services

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions
• CN18- Insufficient access to integrated care programs for behavioral health and physical health conditions

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

**1.13 REQUIRED CORE COMPONENTS**

a) Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps
   - *In progress.* MHMRA convenes regularly with Harris County Psychiatric Center in a Joint Quality Council and also attends regular meetings to address patients with high recidivism rates of admissions to HCPC. From that list can be compiled a list of patients who may benefit from this step-down model. MHMRA is also a member of the Harris County Mental Health Needs Council, where issues pertaining to gaps and needs of the community are discussed.

b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.
   - *Already completed.* MHMRA produces monthly reports on crisis stabilization services available within the agency, and has eligibility criteria and discharge criteria for each service.

c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will lead to a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients (*e.g.*, a minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming Emergency Department settings)
   - *In progress.* MHMRA convenes regularly with Harris County Psychiatric Center in a Joint Quality Council and also attends regular meetings to address patients with high recidivism rates of admissions to HCPC. From that list can be compiled a list of patients who may benefit from this step-down model.

d) Explore potential crisis residential alternative service models and determine an acceptable and feasible program design for implementation.
   - *In progress.* MHMRA convenes regularly with Harris County Psychiatric Center in a Joint Quality Council and also attends regular meetings to address patients with high recidivism rates of admissions to HCPC. Also, a review of current
literature such as SAMSHA best practices can be reviewed for program design of step-down models.
e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations
  • To be completed. MHMRA will work with the outcomes department and key stakeholders to review impact and access, identify challenges and refine the intervention strategies.

PROJECT VALUATION

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

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

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature.

Cost-Utility Analysis:

Although no direct studies cost-utility related to psychiatric crisis units were found, a study related to housing for persons living with HIV seemed relevant. A cost-utility analysis by Holtgrave and colleagues (2012) was based on data from the Housing and Health (H&H) Study of unstably housed persons living with HIV in Baltimore, Chicago, and Los Angeles. This study combined outcome data with information on intervention costs to estimate the cost-QALY saved. Results indicated the cost-per-QALY-saved due to housing services was $62,493. They also
reported 0.0324 QALY gains due to reduced stress and improved quality of life. For this valuation we focus on housing assistance. Assuming our 100 participants who each participate in crisis residential program, the total value gained from this component would be:

\[
\begin{align*}
100 \quad & \text{(persons served)} \\
0.0324 \quad & \text{(QALY gained)} \\
\times \quad & \$50,000 \quad \text{(life year value)} \\
= \quad & \$162,000 \quad \text{QALY Value}
\end{align*}
\]

Cost-effectiveness and Cost Savings:

Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. We identified several studies that found crisis residential units are more cost effective than inpatient hospitals. In 2002, Fenton and team found the mean cost of an acute treatment episode was 44% lower per treatment in a residential crisis program as compared to treatment at a general hospital. They found an average savings of $17,504 (2012 US dollars) per acute care episode per year (treated in residential crisis program rather than a general hospital). Sledge and colleagues (1996) found similar results; they reported that when patients were randomly assigned to crisis respite care rather than hospitalization, respite care costs were $13,585 (2012 US dollars) lower per year. The average cost savings between these two studies was $15,544.

Based on average savings of $15,544 (Fenton et al., 2002) per acute care episode per year (treated in residential crisis program rather than a general hospital):

\[
\begin{align*}
100 \quad & \text{(persons served)} \\
\times \quad & \$15,544 \quad \text{(savings per episode)} \\
= \quad & \$1,554,400 \quad \text{Cost Savings}
\end{align*}
\]

Additional Cost Savings:

Two additional studies that looked specifically at services provided by a mobile crisis outreach team (MCOT) found lower expenses compared to treatment as usual. Scott (2000) found that patients using MCOT versus normal care were 27 percentage points less likely to be hospitalized, and had $443 lower expenses. In an Australian study, Hugo, Smout, and Bannister (2002) compared inpatient admission between MCOT users and traditional hospital services emergency services. MCOT patients were 30 percentage points less likely to be admitted.

In addition, a study conducted by Adams and El-Mallakh (2009) investigated crisis stabilization services in Kentucky. The authors determined that the cost for one day of care of crisis stabilization was $195 (in 2012 US dollars), while the cost for a day at the state hospital was $488 (in 2012 US dollars) – a savings of $293 per day. Although the Adams and El-Mallakh (2009) study is relevant, the study design did not randomize the patients to ensure comparability between CSU and hospitalization; therefore it was not used to value this project.
Summary and Total Valuation:

This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention. The total expected value of benefits, based on the average of the Fenton article and the Sledge et al. article, is $1,554,400. The Fenton et al. study’s QALY-based estimate was $162,000. The total valuation is $1,716,400 per 100 people served per year.
<table>
<thead>
<tr>
<th>Unique Identifier: 113180703.1.11</th>
<th>RHP PP Reference Number: 1.13.1</th>
<th>Project Components: 1.13.1a, 1.13.1b, 1.13.1c, 1.13.1d, 1.13.1e</th>
<th>Program Title: CRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td></td>
<td></td>
<td>TPI: 113180703</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s): 113180703.3.20 113180703.3.21</td>
<td>Category 3 IT Identifiers: 6.1 10.1</td>
<td>Improvement Target: Percent improvement over baseline of patient satisfaction scores Improvement of functional status</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.13.1: Develop and Implement Crisis Stabilization</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Milestone 1:</strong> P-2. Review mapping and gap analysis of current crisis system <strong>Metric 1:</strong> P.2.1 Produce a written analysis of community needs for crisis services. <strong>Data Source:</strong> Written plan <strong>Goal:</strong> Complete within DY 2.</td>
<td><strong>Milestone 3:</strong> P-4. Hire and train staff to implement the CRU clinic <strong>Metric 1:</strong> P-4.1 Number of staff hired and trained <strong>Data Source:</strong> Human Resource records <strong>Goal:</strong> At least 50% of staff hired and trained.</td>
<td><strong>Milestone 8:</strong> P-6. Evaluate and continuously improve crisis services <strong>Metric 1:</strong> P-6.1 Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles <strong>Data Source:</strong> Quarterly Reports <strong>Goal:</strong> Establish quality improvement goal based on quarterly reports.</td>
<td><strong>Milestone 13</strong> P-6. Evaluate and continuously improve crisis services <strong>Metric 1:</strong> P-6.1 Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles <strong>Data Source:</strong> Quarterly Reports <strong>Goal:</strong> Review quality improvement goal based on quarterly reports.</td>
</tr>
<tr>
<td>Estimated Incentive Payment: $2,204,685.94</td>
<td>Estimated Incentive Payment: $969,458.73</td>
<td>Estimated Incentive Payment: $1,035,970.32</td>
<td>Estimated Incentive Payment: $1,000,937.51</td>
</tr>
<tr>
<td><strong>Milestone 2:</strong> P-3. Develop implementation plans for CRU <strong>Metric 2:</strong> P-3.1 Produce an updated, data-driven, written action plan for development of CRU based on gap analysis and needs. <strong>Data Source:</strong> Written plan <strong>Goal:</strong> Complete within DY2</td>
<td><strong>Milestone 4:</strong> P-5. Review and refine administration of operational protocols and clinical guidelines for a CRU program <strong>Metric 4:</strong> P-5.1 Completion of policies and procedures <strong>Data Source:</strong> Written policy and operations manuals. <strong>Goal:</strong> Completion of policies and procedures by DY3.</td>
<td><strong>Milestone 9:</strong> I-10. Jail Bookings <strong>Metric 1:</strong> I-10. 1 % decrease in county jail bookings <strong>Data Source:</strong> MHMRA records and Harris County Jail records. <strong>Goal:</strong> Reduce county jail bookings by 5% from baseline</td>
<td><strong>Milestone 14:</strong> I-10. Jail Bookings <strong>Metric 1:</strong> I-10.1 % decrease in county jail bookings <strong>Data Source:</strong> MHMRA records and Harris County Jail records. <strong>Goal:</strong> Reduce county jail bookings by 10% from baseline</td>
</tr>
<tr>
<td>Estimated Incentive Payment: $2,204,685.94</td>
<td>Estimated Incentive Payment: $969,458.73</td>
<td>Estimated Incentive Payment: $1,035,970.32</td>
<td>Estimated Incentive Payment: $1,000,937.51</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>N/A</td>
<td>Milestone 5: I-X. Admissions/Readmissions Psychiatric Emergency Service (PES) <strong>Metric 1: I-X.1</strong> Number of inpatient admissions at PES for CRU <strong>Data Source</strong>: MHMRA and public psych hospital records <strong>Goal</strong>: Establish baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 10: Readmissions Psychiatric Emergency Service (PES) <strong>Metric 1: I-X.1</strong> Number of inpatient admissions at PES for CRU <strong>Data Source</strong>: MHMRA and public psych hospital records a. Numerator: Number of patients receiving CRU services admitted to PES b. Denominator: Number of patients receiving CRU services <strong>Data Source</strong>: MHMRA and public psych hospital records <strong>Goal</strong>: Decrease the percentage of ER services by 5% from baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 15: I-X. Readmissions Psychiatric Emergency Service (PES) <strong>Metric 1: I-X.1</strong> Number of inpatient admissions at PES for CRU <strong>Data Source</strong>: MHMRA and public psych hospital records a. Numerator: Number of patients receiving CRU services admitted to PES b. Denominator: Number of patients receiving CRU services <strong>Data Source</strong>: MHMRA and public psych hospital records <strong>Goal</strong>: Decrease the percentage of ER services by 10% from baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Estimated Incentive Payment: $969,458.73</td>
<td>Estimated Incentive Payment: $1,035,970.32</td>
<td>Estimated Incentive Payment: $1,000,937.51</td>
</tr>
<tr>
<td>Milestone 11: I-X. Reduction in Inpatient Public Hospital Admissions <strong>Metric 1: I-X.1</strong> Number of inpatient admissions at HCPC for CRU patients a. Numerator: Number of patients receiving CRU admitted to HCPC b. Denominator: Number of patients receiving CRU services <strong>Data Source</strong>: MHMRA and public psych hospital records</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 16: I-X. Reduction in Inpatient Public Hospital Admissions <strong>Metric 1: I-X.1</strong> Number of inpatient admissions at HCPC for CRU patients a. Numerator: Number of patients receiving CRU admitted to HCPC b. Denominator: Number of patients receiving CRU services <strong>Data Source</strong>: MHMRA and public psych hospital records</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unique Identifier: 113180703.1.11</td>
<td>RHP PP Reference Number: 1.13.1</td>
<td>Project Components: 1.13.1a, 1.13.1b, 1.13.1c, 1.13.1d, 1.13.1e</td>
<td>Program Title: CRU</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------------------</td>
<td>-------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>RHP Performing Provider:</strong> Mental Health and Mental Retardation Authority of Harris County</td>
<td><strong>TPI:</strong> 113180703</td>
<td><strong>1.13.1: Develop and Implement Crisis Stabilization</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td><strong>Category 3 IT Identifiers:</strong></td>
<td><strong>Improvement Target:</strong> Percent improvement over baseline of patient satisfaction scores</td>
<td></td>
</tr>
<tr>
<td>113180703.3.20</td>
<td>6.1, 10.1</td>
<td>Improvement of functional status</td>
<td></td>
</tr>
<tr>
<td>113180703.3.21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
<tr>
<td><strong>Goal:</strong></td>
<td><strong>Goal:</strong></td>
<td><strong>Goal:</strong></td>
<td><strong>Goal:</strong></td>
</tr>
<tr>
<td>Decrease inpatient admissions rate by 5% from baseline</td>
<td>Decrease inpatient admissions rate by 10% from baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong></td>
<td><strong>Estimated Incentive Payment:</strong></td>
<td><strong>Estimated Incentive Payment:</strong></td>
<td><strong>Estimated Incentive Payment:</strong></td>
</tr>
<tr>
<td>$969,458.73</td>
<td>$1,035,970.32</td>
<td>$969,458.73</td>
<td>$1,000,937.51</td>
</tr>
<tr>
<td><strong>Milestone 6:</strong> P-X. Locate, remodel, and furnish a facility for CRU Metric 1: P-X.1 B5 Documented location site and permits. <strong>Goal:</strong> Completion by end of DY3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 12:</strong> I-11. Costs avoided by using lower cost settings Metric 1: I-11.1 Costs avoided by comparing utilization of lower cost alternative settings with higher cost settings (PES/inpatient hospitals) a. Numerator: Cost of services for CRU patients b. Denominator: Total cost for crisis care had it been conducted in hospital <strong>Goal:</strong> Establish baseline cost savings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 17:</strong> I-11. Costs avoided by using lower cost settings Metric 1: I-11.1 Costs avoided by comparing utilization of lower cost alternative settings with higher cost settings (PES/inpatient hospitals) a. Numerator: Cost of services for CRU patients b. Denominator: Total cost for crisis care had it been conducted in hospital <strong>Goal:</strong> Increase cost savings by 5% from baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1: I-10.1 % decrease in county jail bookings</strong> <strong>Data Source:</strong> MHMRA records and Harris County Jail records. <strong>Goal:</strong> establish protocol for defining baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Records from MHMRA, public hospital, and jail</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Records from MHMRA, public hospital, and jail</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> Establish baseline cost savings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Records from MHMRA, public hospital, and jail</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> Increase cost savings by 5% from baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unique Identifier: 113180703.1.11</td>
<td>RHP PP Reference Number: 1.13.1</td>
<td>Project Components: 1.13.1a, 1.13.1b, 1.13.1c, 1.13.1d, 1.13.1e</td>
<td>Program Title: CRU</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td>TPI: 113180703</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>Category 3 IT Identifiers:</td>
<td>Improvement Target: Percent improvement over baseline of patient satisfaction scores Improvement of functional status</td>
<td>1.13.1: Develop and Implement Crisis Stabilization</td>
</tr>
<tr>
<td>113180703.3.20</td>
<td>6.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>113180703.3.21</td>
<td>10.1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Incentive Payment:</td>
<td>$969,458.73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Est. Bundle Amount:</td>
<td>$4,409,371.88</td>
<td>$4,847,293.64</td>
<td>$5,179,851.61</td>
</tr>
</tbody>
</table>

TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY: $19,441,204.66
REFERENCES


Mental Health and Mental Retardation Authority of Harris County
Pass 2
1.13 DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION: INTERIM CARE CLINIC

RHP Project Number: 113180703.1.8  
TPJ: 113180703

Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid.

Intervention(s): The Interim Care Clinic (ICC) is designed to provide initial evaluation and treatment in a single visit. The clinic will include extended evening hours and availability seven days a week.

Need for the project: Although MHMRA routinely operates at or above its state mandated, contracted service capacity, averaging about 8,800 adult consumers served each month, there remains a significant waiting list for services. As of August 31, 2012 the waitlist for adult mental health outpatient services rested at 1,695, a level that has persisted for several years. Furthermore, tenure on the waiting list approached five months, an average of 149.16 days.

Target population: The program targets individuals presenting at the MHMRA Psychiatric Emergency Service (PES) voluntarily, who are not in acute crisis, but who are in urgent need of assessment and treatment to avoid further deterioration of their psychiatric condition. It is anticipated the program will provide service for about 1100 patients.

Category 1 or 2 expected patient benefits: MHMRA will:

- decrease inpatient admissions by 10% from baseline
- increase cost savings amount by amount TBD

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DYS.
1.13 Development of behavioral health crisis stabilization services as alternatives to hospitalization: Interim Care Clinic (ICC)

RHP Project Number: 113180703.1.8

Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

**Project Description:** The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to increase develop a behavioral health crisis stabilization service as an alternative to hospitalization.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious mental illnesses, for the developmentally delayed, and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid. With regard to income, 88% report family size and annual income placing them at or below 133% of the 2012 Federal Poverty Level Guidelines. Only 5.2% of the agency’s clientele report incomes above 100% of FPL. Harris County’s ethnic diversity is reflected in the population served. Agency consumers self-describe the following ethnic backgrounds: African-Americans (34.5%), Anglos (27.1%), persons of Hispanic heritage (26.6%), Asian-Americans (2.8%), and other ethnicities (0.4%).

**Project Description:** The Interim Care Clinic (ICC) is designed to provide initial evaluation and treatment to individuals presenting at the MHMRA Psychiatric Emergency Service (PES) voluntarily. While they are not in acute crisis, they are in urgent need of assessment and treatment to avoid further deterioration of their psychiatric condition. These individuals are diverted from admission to the PES by means of a PES triage process and offered a same day evaluation with an interim care clinic psychiatrist. A clinical social worker and registered nurse are available to provide services as needed. The clinic is designed to be a single-visit clinic; no return or follow-up appointments are given, although patients may return if needed.

The patients targeted for the ICC are patients with a chronic psychiatric diagnosis who are currently on the wait list for MHMRA on-going, outpatient services. Due to the lack of capacity in the outpatient mental health clinics, many are on the waitlist from 6 months to a year before an appointment slot can be offered. The majority are uninsured and even if working they do not have resources to pay for expensive psychiatric medication. As a result, these unemployed and working poor patients are at high risk for psychiatric relapse and preventable hospitalization.

Another target group for this clinic are patients recently discharged from the prison system where they had received psychiatric care. These individuals are often released to half way houses with little or no family support and no income. They often come to our PES service for medication,
and after receiving service, are directed to the Eligibility Center (EC) where they will frequently 
be waitlisted.

Without medications and stabilization, they are at high risk for preventable hospitalization and 
re-incarceration if they become unstable due to their psychiatric condition.

The project proposes to have the clinic available seven days a week, including extended evening 
hours.

**Baseline:** There is currently no publicly-funded interim care service provided through MHMRA 
of Harris County. Individuals who are in urgent need of psychiatric assessment and treatment are 
currently treated in the MHMRA Psychiatric Emergency Service (PES) located at 
Neuropsychiatric Center (NPC). Due to the overwhelming need for these services, the current 
PES has often been forced (for health and safety reasons and elevated risk) to delay registration 
of those seeking voluntary admission to the program, or go on full diversion, forcing patients or 
law enforcement to transport them to nearby hospital emergency rooms in an effort to get back 
on their psychiatric medications. An interim care clinic would allow a portion of those seeking 
voluntary treatment to be directed to a less expense and restrictive alternative.

**Rationale:** While MHMRA has implemented several crisis alternatives, there is still an 
overwhelming need to provide psychiatric evaluation and treatment for those in urgent need. The 
current MHMRA Psychiatric Emergency Services has seen a marked increase in admissions 
since 2008. In 2008, there were 10,998 admissions; in 2011, that number rose to 16,334 
admissions, an increase of 49%. The number brought to the unit by law enforcement also 
increased by 42% during that same time frame. The only other public hospital psychiatric crisis 
access is through Ben Taub Hospital. For a population of 4.2 million people, two access points 
are not adequate to fill the need to address both urgent and emergent crisis services.

Below is a map of the visits to the MHMRA Psychiatric Emergency Service located at NPC. The 
gap between service needs of seriously mentally ill adults in the county and available public 
service capacity is most evident in the waiting list for ongoing outpatient service. MHMRA of 
Harris County routinely operates at or above its state mandated, contracted service capacity, 
averaging about 8,800 adult consumers served each month. At this level, however, access is poor 
for many who apply for service. As of August 31, 2012, the waitlist for adult mental health 
outpatient services consisted of 1,695 individuals, a level that has persisted for several years. 
Further, tenure on the waiting list approached five months, an average of 149.16 days.

**Project Goals:** The goals are to provide a community-based alternative for urgent psychiatric 
care, reduce unnecessary inpatient hospitalizations, reduce general hospital emergency room 
admissions for behavioral health emergencies, improve access to treatment for individuals in 
crisis, and utilize the least restrictive means of stabilizing and treating consumers.

<table>
<thead>
<tr>
<th></th>
<th>DY2</th>
<th>DY3</th>
<th>DY4</th>
<th>DY5</th>
</tr>
</thead>
<tbody>
<tr>
<td>People expected to be served</td>
<td>250</td>
<td>1100</td>
<td>1100</td>
<td>1100</td>
</tr>
</tbody>
</table>
The 5-year expected outcome(s): The expected 5-year outcome is to have a fully functional interim care clinic capable of serving up to 300 patients a month. Additionally, we expect to see a decrease in crisis services for patients receiving ICC services, a decrease in psychiatric hospital admissions for patients receiving ICC services, and a decrease in the rate of diversions for the PES and number of psychiatric diversions for the neighboring public hospital emergency department. Although they may be in urgent need, they may be stabilized prior to an emergent episode, and thus remain in the community. These goals are consistent with the regional and community needs as discussed below.

Anticipated Challenges: The primary challenge is linkage to ongoing care. This challenge will be addressed through stakeholder meetings with other behavioral health care providers and expansion of outpatient behavioral health services. Additionally, linkage is addressed in other MHMRA DSRIP proposals.

Regional Goals and Community Needs: This project directly meets several broad goals identified by the regional needs assessment. First, it improves on existing programs and infrastructure by filling a void that is unmet by existing psychiatric outpatient clinics and psychiatric emergency services. Second, it increases access to specialty care services by providing treatment in an additional Houston location. The program also offers a preventative, patient-centered approach that provides brief psychiatric care to those in urgent need. The proposed program will also complement the regional need to develop a culture of “best practices,” whereby the patient plays a more active role as a stakeholder by completing patient satisfaction surveys. The ICC would decrease the rate of PES diversions relative to the number of treated crisis episodes. In addition, the neighboring public hospital emergency department is expected to report fewer psychiatric diversions.
The PES is located next to Ben Taub General Hospital (BTGH) a level one trauma center that in the past year has gone on diversion several times a month as a result of overcrowding; one factor is an excess of psychiatric patients due to the PES’s being on diversion.

**Unique Community Need Identification numbers:** The Interim Care Clinic will address the following community needs:
- **CN2-Insufficient Access to Behavioral Health**
- **CN5- Integrated Care for Behavioral Health**
- **CN12- Improved Access to Patient Education**
- **CN14-Reduction of ER Services**

**Relationship to other Projects:** At this time, there is not enough information available from the RHP to describe how this project may or may not be related to other RHP DSRIP proposals. However, the proposed project is similar to several MHMRA DSRIP proposals, including the expansion of the Crisis Residential Unit, the expansion of the Chronic Consumer Stabilization Initiative, and the redesign of the transition from HCPC to MHMRA Outpatient Aftercare. All three proposals seek to expand psychiatric stabilization while reducing inpatient admissions. It is hoped that many of the Interim Care patients could access these less restrictive and more appropriate care levels in lieu of hospitalization. Also, this project will interface with the expansion of outpatient mental health clinic services, the collaborative primary medical and behavioral health care, and with integrating substance abuse treatment services into mental health services by referring individuals into the appropriate ongoing care alternative.

**Related Category 3 Outcome Measure(s):**
**IT-6.1** Percent improvement over baseline of patient satisfaction scores
**IT-9.1:** Decrease in the number of individuals receiving ICC intervention who had a potentially preventable admission/readmission to a criminal justice setting during the demonstration years

**Reasons/rationale for selecting the outcome measure:**
Measurement of patient satisfaction is a key indicator of patient-centered care and has been targeted as a quality indicator by national organizations dedicated to improvement in patient outcomes, e.g., the National Council for Quality Assurance. Furthermore, if patients and their family are satisfied with services then we can assume they are being provided for adequately. On the other hand, if patients are dissatisfied having an avenue to express their concerns is important to empowering our clients.

1) Decrease in rate of diversion for PES
   **Reasons/rationale for selecting outcome measure:**
   Over the past five years there has been an increase in the number of diversions in our PES due to increasing volume. The ICC would see 12-14 patients per day of patients with lower level crisis needs allowing the PES to focus on the more acute patients.

2) Decrease psychiatric diversions in the neighboring public hospital emergency department. As noted above, this indicator would be expected to respond favorably to increased capacity at our PES.
3) Psychiatric treatment of individuals with serious mental illnesses has long been documented to significantly reduce subsequent psychiatric hospitalizations. It is hypothesized that an individual treated in the interim care clinic will show reductions (relative to comparable pre-treatment periods) in 30-day, 90-day, and 365-day rates of public psychiatric hospital admissions. Mirror analyses will compare patients’ own histories with performance following intervention.

4) Psychiatric treatment also reliably decreases the need for psychiatric crisis care over time. Individuals receiving interim clinic care are expected to make fewer bona fide crisis visits as compared to own prior history.

Reason/Rationale for selecting outcome measures:
By providing medication and psychiatric intervention, the ICC would prevent patients with chronic mental conditions from going into crisis and requiring expensive psychiatric hospitalizations.

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

1.13.1 Core Components
In order to develop such a program, the following option (1.13.1) and core components were chosen:

a) Convene community stakeholders who can support the development of psychiatric urgent care services to update the gap analysis of the current community crisis system and revise a specific action plan to address identified gaps.
   - In progress. MHMRA convenes regularly with Harris County Psychiatric Center in a Joint Quality Council. MHMRA is also a member of the Harris County Mental Health Needs Council, where issues pertaining to gaps and needs of the community are discussed. Also, a pilot project resulted in outcomes that indicate an Interim Care Clinic can have a significant impact on reduction of penetration further into costly emergency services.

b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.
   - Already completed. MHMRA produces monthly reports on crisis stabilization services available within the agency, and has eligibility criteria and discharge criteria for each service.

c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then update the gap analysis that will result in a data-driven plan to further refine the crisis stabilization initiative of interim care.
clinics that will meet the behavioral health needs of the patients. This will build upon the DSHS Crisis Redesign process.

- A recent pilot project resulted in outcomes that indicate an Interim Care Clinic can have a significant impact on reduction of penetration further into costly emergency services.

d) Explore potential crisis alternative service models and determine an acceptable and feasible program design for implementation.

- This has already been done through DSHS Crisis Redesign and through a pilot project that resulted in positive outcomes on hospital diversion by utilizing an Interim Care model.

e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

- To be completed. MHMRA will work with the outcomes department and key stakeholders to review impact and access, identify challenges and refine the intervention strategies.

**Project Valuation:** In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

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

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature.
**Cost-Utility Analysis:** When comparing this expansion of Interim Care Clinic capacity to current service strategies, the project can best be likened to an innovative model for delivering medication only services, a strategy most similar to Level One of the current utilization management scheme. Individuals receiving service package one care are often prescribed psychotropic medication, but do not receive therapy. One QALY-related study (Chouinard & Albright, 1997) found individuals with schizophrenia receiving medications versus a placebo gained, on average, seven times the quality-adjusted years than without medications (QALY = .087). Furthermore, Schoenbaum, M., Miranda, J., Sherbourne, C., Duan, N., & Wells, K. (2004 found depressed patients who received medications improved to an average QALY of .0148 compared to those with no medications. Averaging these QALY’s together results in a QALY of .0509 for receiving medications compared to not receiving medications.

Assuming the program would serve 100 patients a year:

\[
\begin{align*}
100 & \quad \text{(persons served)} \\
0.0509 & \quad \text{(QALY gained)} \\
\times & \quad \text{($50,000$ \text{ \text{life year value}})} \\
= & \quad 254,500 \quad \text{Level 1 QALY Value}
\end{align*}
\]

**Cost-Effectiveness and Cost Savings:** Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. We used local information to describe cost-savings. In the year prior to contact with the interim clinic there were a total of 52 hospitalizations at HCPC and 453 individuals admitted to NPC. After the first interim clinic visit, no HCPC or NPC visits were logged by this sample. Care at the Interim Care Clinic produced a reduction in hospitalizations at HCPC by 4.7% and NPC visits by 50.8%. Based on this information we can calculate the cost savings as follows:

\[
\begin{align*}
100 & \quad \text{Number of Consumers Served} \\
.047 & \quad \text{Percent of Reduction in Hospitalization} \\
10.25 & \quad \text{Average length of stay at HCPC} \\
\times & \quad \text{($700$ \text{ Per diem cost of HCPC})} \\
$33,722.50 & \quad \text{Hospital Savings 1}
\end{align*}
\]

\[
\begin{align*}
100 & \quad \text{Number of Emergency Psychiatric Visits} \\
0.508 & \quad \text{Percent of Reduction in Emergency Psychiatric Visits} \\
\times & \quad \text{($700$ \text{ Per visit cost: Psychiatric Emergency Care})} \\
$35,560.00 & \quad \text{Hospital Savings 2}
\end{align*}
\]

**Summary and Total Valuation:** This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention. The total valuation is $323,783 per 100 patients served based on the QALY estimate and cost savings ($254,500 + 33,722.50 + $35,560.00). This concludes the valuation for the proposed project.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1: P-2:** Review mapping and gap analysis of current crisis system  
**Metric 1: P.2.1**  
Produce a written analysis of community needs for crisis services.  
**Data Source:** Written plan  
**Goal:** complete by end of DY 2

**Milestone 3: P-4:** Hire and train staff to implement the interim care clinic  
**Metric 1: P-4.1** Number of staff hired.  
**Data Source:** Human Resource Records  
**Goal:** At least 50% of staff will be hired/ trained by the end of Y3.

**Milestone 6: P-6:** Evaluate and continuously improve crisis services  
**Metric 1: P-6.1** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles  
**Data Source:** Quarterly Reports  
**Goal:** complete one cycle per year

**Milestone 10: P-12:** Evaluate and continuously improve crisis services  
**Metric 1: P-6.1** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles  
**Data Source:** Quarterly Reports  
**Goal:** complete one cycle per year

<table>
<thead>
<tr>
<th>Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,393,792.72</td>
<td>$1,042,845.83</td>
<td>$846,379.15</td>
<td>$814,862.73</td>
</tr>
<tr>
<td>Year</td>
<td>Milestone</td>
<td>Description</td>
<td>Metric</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------------</td>
<td>--------</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Milestone 2: P-3:</td>
<td>Develop implementation plans for needed psychiatric interim care clinic capacity</td>
<td>Metric 1: P-3.1 Produce data-driven written action plan for development of specific interim care clinic capacity based on gap analysis and assessment of needs.</td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Milestone 4: P-5:</td>
<td>Review and refine administration of operational protocols and clinical guidelines for an interim care clinic</td>
<td>Metric 1: P-5.1 Completion of policies and procedures.</td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Milestone 7: I-X:</td>
<td>Ben Taub General Hospital (BTGH) ER Admissions</td>
<td>Metric 1: I-X.1 Number of BTGH ER Admissions</td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td>Milestone 11: I-X:</td>
<td>Ben Taub General Hospital (BTGH) ER Admissions</td>
<td>Metric 1: I-X.1 Number of BTGH ER Admissions</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>Milestone 5: I-X.</strong> Psychiatric Emergency Service (PES) Readmissions and Inpatient Public Hospital Admissions <strong>Metric 1: I-X.1</strong> Number of inpatient admissions at PES/HCPC for ICC <strong>Data Source:</strong> MHMRA and public psych hospital records <strong>Goal:</strong> Establish baseline</td>
<td><strong>Milestone 8: I-11.</strong> Costs avoided by using lower cost settings <strong>Metric: 1: I-11.1</strong> Costs avoided by comparing utilization of lower cost alternative settings with higher cost settings (ICC versus PES/inpatient hospitals) a. Numerator: Average cost of services for ICC patients b. Denominator: Total average cost for crisis care to individuals in the regional partnership study area. <strong>Data Source:</strong> Records from MHMRA, public hospital, &amp; jail <strong>Goal:</strong> Establish baseline cost savings</td>
<td><strong>Milestone 12: I-11.</strong> Costs avoided by using lower cost settings <strong>Metric: 1: I-11.1</strong> Costs avoided by comparing utilization of lower cost alternative settings with higher cost settings (ICC versus PES/inpatient hospitals) a. Numerator: Average cost of services for ICC patients b. Denominator: Total average cost for crisis care to individuals in the regional partnership study area. <strong>Data Source:</strong> Records from MHMRA, public hospital, &amp; jail <strong>Goal:</strong> Increase cost savings by 5% over baseline</td>
<td></td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment:**

- Year 2: $1,042,845.83
- Year 3: $846,379.15
- Year 4: $814,862.73
- Year 5: Estimated Incentive Payment:
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
| **Milestone 9: I-X:** Reduction in rate of NPC diversions  
**Metric 1:** reduction in the rate of NPC diversions  
a. Numerator: Number of diversions  
b. Denominator: Number served in PES and ICC  
**Data source:** Diversion records from NPC  
**Goal:** Reduce rate of diversions by 5% |  | **Milestone 13: I-X:** Reduction in rate of NPC diversions  
**Metric 1:** reduction in the rate of NPC diversions  
a. Numerator: Number of diversions  
b. Denominator: Number served in PES and ICC  
**Data source:** Diversion records from NPC  
**Goal:** Reduce rate of diversions by 10% |  |
| Estimated Incentive Payment: | Estimated Incentive Payment: |  |  |
| $846,379.15 | $814,862.73 |  |  |

**Year 2 Estimated Milestone Bundle Amount:** $2,787,585.44  
**Year 3 Estimated Milestone Bundle Amount:** $3,128,537.48  
**Year 4 Estimated Milestone Bundle Amount:** $3,385,516.60  
**Year 5 Estimated Milestone Bundle Amount:** $3,259,450.94

**TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY:** $12,561,090.46
REFERENCES


Mental Health and Mental Retardation Authority of Harris County
Pass 3
1.12 ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE: Clubhouse

RHP Project Number: 113180703.1.9 \hspace{1cm} TPI: 113180703

**Provider:** The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. We will be contracting St. Joseph’s House to provide psychosocial rehabilitative services. St Joseph House is an accredited Clubhouse and adheres to the standards of the International Center for Clubhouse Development (ICCD).

**Intervention(s):** The intervention is the ICCD Clubhouse Model, which is a day treatment program for psychosocial rehabilitation of adults diagnosed with a serious and persistent, chronically disabling mental health problem.

**Need for the project:** Estimates place approximately 78,000 adults with severe mental illness unable to access treatment from the public or private mental health systems in Harris County. The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the current waiting list of 1,641 for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service. At present, St. Joseph House is the sole provider of service of this type in Harris County. The current St. Joseph House capacity is limited to 60 active members.

**Target population:** Seriously mentally ill adults in Harris County with social and vocational functional impairments.

**Category 1 or 2 expected patient benefits:**

- Increase utilization of services to 209 patients more than baseline by DY5.
- A 10% decrease from baseline in intensive psychiatric and jail service admissions/bookings (i.e. psychiatric hospital, psychiatric emergency department, jail) by DY5.
- Increase in days worked by 10% over baseline by DY5.

**Category 3 outcomes:** MHMRA expects to increase one domain of patient satisfaction with communication with providers by 10% from baseline by DY5.
1.12 Enhance service availability of appropriate level of behavioral health care: Clubhouse Expansion

**RHP Project Number:** 113180703.1.9

**Performing Provider/TPI:** Mental Health and Mental Retardation Authority of Harris County/113180703

**Project Description:**
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to increase capacity of psychosocial rehabilitation in the county. The MHMRA services more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid. With regard to income, 88% report family size and annual income placing them at or below 133% of 2012 Federal Poverty Level Guidelines. Only 5.2% of the agency’s clientele report incomes above 100% of FPL. Harris County’s ethnic diversity is reflected in the population served. Agency consumers self-describe the following ethnic backgrounds: African-Americans (34.5%), Anglos (27.1%), persons of Hispanic heritage (26.6%), Asian-Americans (2.8%) and those reporting other ethnicities (0.4%).

MHMRA will be contracting with St. Joseph House to provide psychosocial rehab services. St Joseph House is an accredited Clubhouse and adheres to the standards of the International Center for Clubhouse Development (ICCD). The ICCD Clubhouse Model is a day treatment program for rehabilitating adults diagnosed with a serious and persistent mental health problem. The goal of the program is to contribute to the recovery of individuals through use of a therapeutic environment that includes responsibilities within the Clubhouse (e.g., clerical duties, reception, food service, transportation, financial services), as well as through outside employment, education, meaningful relationships, housing, and an overall improved quality of life through objective setting and review. Individuals who participate in the Clubhouse are called "members." Fundamental elements of their participation include openness and inclusion in type of work activities and choice of staff, opportunities to strengthen decision-making skills, and a lifetime right of reentry and access to all Clubhouse services.

St Joseph House actively works on jail diversion with the DA’s office and the three courts in Houston with mental health dockets.
Each individual is welcomed, wanted, needed, and expected each day and is considered a critical part of a community engaged in important work. A core component of the program is the "work-ordered day," the structure around which daily activity is organized. The day-to-day operation of the Clubhouse is the responsibility of members and staff, who work side by side in a rehabilitative environment. Other core components include transitional, supported, and independent employment through which members can secure jobs at prevailing wages in the wider community; access to community support, such as housing and medical services; assistance in accessing educational resources; "reach-out" to maintain contact with all active members; participation in program decision-making and governance; and evening, weekend, and holiday social programs.

St Joseph House staff who function as generalists maintain a caseload including managing employment placements, housing issues, and access to community supports. They also are responsible for the ongoing work of the Clubhouse and help organize and participate in social activities. Staff have diverse life experiences and backgrounds in a variety of disciplines, including psychology, counseling, social work, and education. Clubhouse members do not pay dues or membership fees. Their attendance is voluntary, and they can participate as little or as much as they choose. Because the membership of the St. Joseph’s House is fluid there are three methods for describing service output. First, there are daily attendees whose numbers are limited by the number of available staff, as reflected in average daily visits. Second, there are active members who have attended services within the past 3 months. Generally, there are twice as many active members as attend on an average day. And last, there are permanent members who have been active within the past year, a number generally several times the active membership. St Joseph House is the only program in Houston accredited by the ICCD.

**Project Description:** The current proposal has two ways in which it will expand psycho-social rehabilitation for the mental health community in Harris County. First, the current St. Joseph House will add 4 additional staff in order to expand current service capability from 60 daily attendees to 90. Second, a new location will be opened that will have a service capacity of 30 daily member visits. In order to address this issue we will choose to focus on project option 1.12.2: Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

Roughly 90% of current members are eligible for SSI and/or SSDI, as well as Medicare and Medicaid. As part of the program, every effort is made to qualify clubhouse participants for benefits. Around 70% of the participants are indigent at any given time. Many have difficulty with the rigors of the process, or have been unable to complete it due to destabilizing factors in their lives. The continuity intrinsic to clubhouse involvement provides a unique opportunity for people to follow through with these efforts. On average, two-thirds of the members are receiving SSI/SSDI payments and commensurate Medicare/Medicaid benefits.

**Rationale:** The “Clubhouse” model of rehabilitation is well-researched method of psychiatric rehabilitation, successfully implemented for more than sixty years (Fountain House, 1999, Bond et al. 1984, Bond et al. 1995). The model provides vocationally oriented rehabilitation opportunities for its members in a normalized social setting where members with serious mental health conditions are welcomed, wanted, needed, and expected each day and are considered a critical part of a community engaged in important work.
illness may pursue recovery-oriented goals. These programs have proven effective in reducing the demoralization typically attendant to serious and persistent mental illness and have been found to reduce member’s use of intensive services such as psychiatric hospitalization and jail bookings (Johnson & Hickey, 1999). Psychosocial rehabilitation and vocational rehabilitation using the ICCD Clubhouse Model, including work-oriented programs in-house and opportunities to work for money in the community. A major goal of this model is also to help consumers reach their highest level of independence.

The community mental health system in Harris County has a limited capacity for service that is insufficient to the needs of its residents. The Mental Health Needs Council of Harris County has estimated that 153,000 of the 552,000 Harris County adults with mental illness have a severe mental illness (Depression, Bipolar Disorder, and Schizophrenia). These individuals are among the 96,200 Harris County adults who have no public (Medicaid or Medicare) or private health insurance and therefore, are totally dependent on the public mental health service system for treatment. In 2007, approximately 27,000 adults received services from the public mental health system; 18,200 of these were uninsured (a number representing only 19% of estimated need). By deduction, one can conclude that approximately 78,000 adults with severe mental illness failed to access treatment from the public or private mental health systems. The rate of unemployment among MHMRA adult clients with serious mental illness is estimated at 81%.

St. Joseph House is currently the only Harris County provider of clubhouse model psychosocial rehabilitation services. The ICCD Clubhouse Model is SAMHSA accredited, and on the National Registry of Evidence-based Programs and Practices (NREPP).

**Baseline:** Currently, MHMRA does not have a psychosocial rehabilitation program. However, the St. Joseph House currently has one location that serves 120 permanent members, and about 60 individuals who attend daily. A site for the second location of the St. Joseph’s House program has not been identified yet.

**Goals:** The goals of the program will be to help individuals who have a chronic mental illness, and many of whom are homeless, develop vocational skills, engage in employment related activities, develop linkages to assist with housing, and medical and dental care. The hope is to enable individuals with chronic mental illness to become productive members of the community. In making employment a central goal, it emphasizes a means for people to regain a sense of identity and self-worth, and begin contributing again to society in social and economic terms.

**Expected 5-year Outcomes:** The five year goal is to enhance service availability at the original location and open a second location of the ICCD model Clubhouse program tailored to serve at least a combined 209 permanent members per year with chronic mental illness. The milestones we selected to measure our progress toward this goal are to reduce unnecessary inpatient hospitalizations, reduce criminal recidivism, and to increase employment among participants. The rationale for selecting these outcomes is to find the strongest parameters that demonstrate an increase in participants’ quality of life as well as any reduction in costs borne by society, and to do it with obtainable and quantifiable measures.

**Anticipated Challenges:** Locating a site and establishing a new location is a challenge due to the needs of the program; however, modifications can be made to the facility as needed.
Regional Goals: The proposed project directly meets broad goals identified by the regional needs assessment. First, it improves and builds upon an existing program, which has shown positive gains in providing best-practices for patient-centered care. Furthermore, by providing enhanced, evidence-based services to patients the program will meet the regional goal set out above. Moreover, the program supports the regional goal of developing a culture of patient-centered care whereby the patient/consumer plays a more active role as a stakeholder. Further, work will continue with clubhouse programs in other Texas cities to increase awareness and availability of psychosocial rehabilitation, a significant step in the recovery process.

Unique Community Need Identification numbers: Specific community needs are also addressed through the proposed program:
- CN3-Inadequate access to Behavioral Health Care
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Relation between Project Choices and Community Needs: Expansion of outpatient behavioral health services will address the community needs above by providing greater access to behavioral health care, thereby offsetting the increased use of costly, intensive medical and psychiatric emergency services. Furthermore, a larger behavioral health workforce within MHMRA will provide more opportunities for collaboration between providers and for patient education. MHMRA clinicians already engage in a variety of community collaborations and education activities, despite their tremendous workload. With the addition of qualified behavioral health personnel, more services can be provided. There is currently little psychosocial rehabilitation available, despite its demonstrated success in helping people with mental illness improve their quality of life and avoid institutionalization in hospitals and prisons. This project will help to provide a critical step toward recovery for the people of Harris County.

Relationship to other Projects:
The proposed project is similar to several MHMRA DSRIP proposals in its goals, including the expansion of outpatient behavioral health services within adult outpatient clinics and the project intended to enhance the intensity of behavioral outpatient services. Extending outpatient behavioral health specialty service and increasing the intensity of these services will together ultimately provide more responsive, appropriate levels of care. Outcomes of such services provided are expected to have an impact on patient satisfaction, preventable hospital admissions, and re-admissions; and will likely reduce costs by replacing high-intensity, high-cost services with routine outpatient mental health care. In addition, a proposed project to improve continuity of care for discharged psychiatrically hospitalized patients will capitalize on the expansion of outpatient services.

Plan for Learning Collaborative: Consumer satisfaction with access to services, an outcome to be assessed with input from consumer groups, patients and family members will involve all in the quality improvement loop. Similarly, rates of public psychiatric hospitalization will be
presented to public psychiatric hospital representatives with an invitation for them to provide input on the improvement process.

**Project Valuation:** In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions the common health goal, or outcome, is the number of life-years added. The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature.

**Cost-Utility Analyses**

A review of the scientific literature failed to produce QALY-based studies of cost utility of psychosocial clubhouse model rehabilitative services.

**Cost-effectiveness and Cost Savings**

Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. We did identify benefit-cost studies that were related.

DiMasso and colleagues (2001) performed an outcome study of the clubhouse model, contrasting vocational and hospital outcomes for engaged vs. poor attenders. They reported average reductions of 4.31 psychiatric hospitalizations during the 18 months following clubhouse program admission. This rate converts to an annual reduction of 2.87 hospital admissions per person. Given a local average length of stay of 10.25 days at a cost of $705/day, a savings of $20,739/person/year (2012, US dollars) can be calculated.

Bond (1984) estimated a savings of $7,282 in reduced psychiatric hospital care for clubhouse participants over the 9 months studied. Annualizing the rate ($7,282 x 1.33=$9,685) and
converting to 2012 dollars yields an estimate of $21,474.68 savings per person per year for clubhouse participants.

Averaging the two estimates ($20,739 and $21,474.68) yields a single estimated value of $21,107 per person served.

\[
\frac{100 \text{ (persons served)}}{\times \frac{21,107 \text{ (cost savings per person served)}}{= \$2,110,700 \text{ QALY valuation}}}
\]

Additional Savings

Current research indicates additional savings in the form of improved vocational outcomes and reduced jail costs using this treatment model with this population.

**Total Valuation**

This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). **The total valuation is $2,110,700 per 100 people served per year.**
<table>
<thead>
<tr>
<th>Unique Identifier: 113180703.1. 9</th>
<th>RHP PP Reference Number: 1.12.2</th>
<th>Project Components: NA</th>
<th>Program Title: Clubhouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td>TPI: 113180703</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Measure(s): Decrease in MH/criminal settings</td>
<td>113180703.3.18</td>
<td>IT-9.1</td>
<td>Readmissions to criminal justice settings</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Milestone 1: P-2.</strong> Identify licenses, equipment requirements and other components needed to implement and operate options selected. <strong>Metric 1: P-2.5.</strong> Develop a project plan and timeline detailing operational needs and equipment and components. <strong>Data Source:</strong> Written Project Plan</td>
<td><strong>Milestone 3: P6.</strong> Establish behavioral health services in new community-based settings in underserved areas. <strong>Metric 3: P-6.1</strong> Number of new community-based settings where behavioral health services are delivered. <strong>Data Source:</strong> Project documentation and MHMRA records. <strong>Goals:</strong> Provide documentation of patients being served by new program and enhanced program.</td>
<td><strong>Milestone 6: I-11.</strong> Increased utilization of community behavioral healthcare. <strong>Metric 6: I-11.1 Percent</strong> utilization of community behavioral healthcare services. <strong>Data Source:</strong> MHMRA records. <strong>Goal:</strong> Serve 80 permanent members more than baseline.</td>
<td><strong>Milestone 9: I-11.</strong> Increased utilization of community behavioral healthcare. <strong>Metric 9: I-11.1 Percent</strong> utilization of community behavioral healthcare services. <strong>Data Source:</strong> MHMRA records. <strong>Goal:</strong> Serve 209 permanent members more than baseline.</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $720,802.12</td>
<td><strong>Estimated Incentive Payment:</strong> $545,523.36</td>
<td><strong>Estimated Incentive Payment:</strong> $596,135.72</td>
<td><strong>Estimated Incentive Payment:</strong> $573,387.89</td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan Region 3
<table>
<thead>
<tr>
<th>Unique Identifier: 113180703.1.9</th>
<th>RHP PP Reference Number: 1.12.2</th>
<th>Project Components: NA</th>
<th>Program Title: Clubhouse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RHP Performing Provider:</strong> Mental Health and Mental Retardation Authority of Harris County</td>
<td><strong>TPI:</strong> 113180703</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Related Category 3 Measure(s):**
- Decrease in MH/criminal settings

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 2: P-4:</strong> Hire and train staff to operate and manage project <strong>Metric 2: P-4.1:</strong> Number of staff secured and trained <strong>Data Source:</strong> HR records <strong>Goal:</strong> hire 4 generalist staff members</td>
<td><strong>Milestone 4: I-1:</strong> Increased utilization of community behavioral healthcare <strong>Metric 4: I-1.1:</strong> Percent utilization of community behavioral healthcare services. <strong>Data Source:</strong> MHMRA records <strong>Goal:</strong> establish baseline and increase to 20 additional permanent members</td>
<td><strong>Milestone 7: I-X:</strong> Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions <strong>Metric 7: I-X.1:</strong> Percent of individuals who were admitted to inpatient facilities. <strong>Data Source:</strong> MHMRA and HCPC records <strong>Goal:</strong> A 5% decrease from baseline in PES/HCPC admissions</td>
<td><strong>Milestone 10: I-X:</strong> Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions <strong>Metric 10: I-X.1:</strong> Percent of individuals who were admitted to inpatient facilities. <strong>Data Source:</strong> MHMRA and HCPC records <strong>Goal:</strong> A 10% decrease from baseline in PES/HCPC admissions</td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment:**
- Year 2: $720,802.12
- Year 3: $545,523.36
- Year 4: $596,135.72
- Year 5: $573,387.90
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
| **Milestone 5:** I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions  
**Metric 5:** I-X.1. Percent of individuals who were admitted to inpatient facilities.  
**Data Source:** Psychiatric Emergency Services (PES) records are part of the MHMRA electronic record. Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records  
**Goal:** Establish baseline | **Milestone 8:** I-X. Days in employment related activities  
**Metric 8:** I-X.1. number of average days worked per member  
**Data Source:** MHMRA, St. Joseph’s House  
**Goal:** establish baseline in employment as determined by average number of work days for permanent members | **Milestone 11:** I-X. Days in employment related activities  
**Metric 11:** I-X.1. number of average days worked per member  
**Data Source:** MHMRA, St. Joseph’s House  
**Goal:** increase average number of work days for permanent members by 5% |
| **Estimated Incentive Payment:** | **Estimated Incentive Payment:** | **Estimated Incentive Payment:** |
| $545,523.36 | $596,135.72 | $573,387.89 |
| **Year 2 Estimated Milestone Bundle Amount:** | **Year 3 Estimated Milestone Bundle Amount:** | **Year 4 Estimated Milestone Bundle Amount:** | **Year 5 Estimated Milestone Bundle Amount:** |
| $1,441,604.24 | $1,636,570.08 | $1,788,407.16 | $1,720,163.68 |
| **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** | | | | $6,586,745.15 |
References


1.10 EXPAND SPECIALTY CARE CAPACITY: Lighthouse Mental Health Clinic

RHP Project Number: 113180703.1.10  
TPI: 113180703

Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves about 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received services in FY12, 60.0% were medically indigent and 32% had Medicaid. MHMRA plans to partner with The Lighthouse of Houston for this project. The Lighthouse, established in 1939, serves approximately 11,000 people each year and is a member agency of the United Way of Greater Houston. The primary goal of the Lighthouse is providing direct service to the individual.

Intervention(s): MHMRA proposes to establish behavioral healthcare clinic within the Lighthouse facility in order to provide mental health treatment capacity for persons with visual impairment to include identification of behavioral health needs, interventions, case management, patient and family education and coordination with primary care. The team (to include a director, 2 therapists, 1 intake counselor, a part-time nurse and psychiatrist) will develop services to address the specialized needs of persons with visual impairment with a mental health disorder to support wellness and independent functioning in the community.

Need for the project: Persons affected with blindness and visual impairment often experience difficulties in several life domains, including the development of behavioral health problems. The loss of independence associated with visual impairment can be a significant risk factor for depression and substance abuse disorders. Depression, a common and significant problem in and of itself, frequently also leads to negative functional outcomes in rehabilitation services for the visually impaired. Too often individuals with comorbid vision loss and depression do not seek services, and when they do, services are limited in scope, focusing exclusively on mental health issues to the exclusion of comorbid vision loss. Considering these consequences and the additional barriers faced by visually impaired persons in accessing mental health services, it seems advisable to integrate behavioral health services into the vision rehabilitation system.

Target population: The target population for this service will be individuals with visual impairment in need of behavioral health (mental health and substance abuse) services.

Category 1 or 2 expected patient benefits: Increase specialty care clinic volume from current state (no services) to 110 service recipient per year by DY5.

Category 3 outcomes: MHMRA expects to increase patient satisfaction with communication with providers by 10% from baseline by DY5. Also, an decrease in psychiatric symptoms by 10% by DY5.
1.9 Expand Specialty Care Capacity: Lighthouse

**RHP Project Number:** 113180703.1.10

**Performing Provider/TPI:** Mental Health and Mental Retardation Authority of Harris County/113180703

**Project Description:**
*The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to expand a specialty care mental health clinic for the visually impaired.*

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management, and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received IDD services in FY12, such as those being proposed in this project, 34.1% were medically indigent and 57.1% had Medicaid. With regard to income, 88% report family size and annual income placing them at or below 133% of 2012 Federal Poverty Level Guidelines. Only 5.2% of the agency’s clientele report incomes above 100% of FPL. Harris County’s ethnic diversity is reflected in the population served. Agency consumers self-describe the following ethnic backgrounds: African-Americans (34.5%), Anglos (27.1%), persons of Hispanic heritage (26.6%), Asian-Americans (2.8%) and other ethnicities (0.4%).

MHMRA plans to partner with the Lighthouse of Houston for this project. Established in 1939, the Lighthouse serves approximately 11,000 people each year and is a member agency of the United Way of Greater Houston. The primary goal of the Lighthouse is providing direct service to individuals with blindness or visual impairment. This includes not only providing direct service, but also a continual commitment to improving the quality and relevance of this service. All other organizational activities and functions are in support of this primary focus and have as their goal the development and dissemination of better service designs and interventions in order to enhance the optimal functioning of the individual.

**Project Description:** Along with the Lighthouse, MHMRA proposes to expand behavioral healthcare capacity for persons with visual impairment to include identification of behavioral health needs, interventions, case management, patient and family education, and coordination with primary care. The proposed site for this project is a recently purchased facility by the Lighthouse of Houston, which is adjacent to the Lighthouse of Houston and MHMRA on West Dallas in Houston. The proposed project will develop a specialized behavioral health team consisting of mental health, physical health, case management services, wraparound supports, and adaptive technology. The team will develop services to address the specialized needs of persons with visual impairment with a mental health disorder to support wellness and independent functioning in the community. This project meets the Delivery System Incentive
Reform Payment (DSRIP) Pool 1115(a) waiver component 1.9, Enhance service availability to appropriate levels of care—option 1.9.2 Improve access to specialty care.

**Goals and Relationship to Regional Goals:** The project will focus on the development of specialized mental health services for persons with visual impairment. Specialized services will include: (1) assessment of behavioral health needs in children and adults with visual impairment and (2) development and implementation of interventions for this population, including cognitive behavioral interventions, pharmacological interventions, case management support, and patient and family education. This expansion is expected to provide access to outpatient mental health services that will decrease the severity of psychiatric symptoms in the target population. Improved patient satisfaction is also expected as a result of the expansion of specialty services. These goals are consistent with the regional goals and community needs discussed below.

**Regional Goals:** The project will increase access to specialty care in Harris County and will transform behavioral healthcare for the target population by providing timely, coordinated clinical care. When the behavioral health needs of people with impaired vision and mental illness are not treated until a crisis occurs, interventions tend to focus on episodic, emergent care without adequate coordination of aftercare. The project will provide coordinated care to prevent crises or resolve them with successful transition into stable maintenance. Furthermore, increasing access to specialized services will improve satisfaction and behavioral health outcomes for the target population.

**Challenges:** One of the challenges will be hiring and training the appropriate level of staff to provide increased access and service to the targeted population. The proposed project will develop the workforce of clinicians who are competent to work with the target population and are comfortable doing so. MHMRA will continue to build upon existing partnerships with local universities, medical schools, public and private Medicaid providers, and other agencies to develop clinicians who are skilled and willing to treat people with impaired vision, thereby expanding the pool of competent community providers. The contractual agreements between MHMRA and medical schools and universities are already in place to provide internships and practicum opportunities to students and residents in child psychiatry, psychology, nursing, and social work. The Lighthouse of Houston also has well-established partnerships with the medical community, which will facilitate collaboration, development of specialized workforce, and integration of care.

**Five-Year Expected Outcome for Provider and Patients:** MHMRA expects to see an increase in utilization of specialty care services for as many as 300 patients over the DSRIP period. The following table illustrates the estimated flow of patients by DY.

<table>
<thead>
<tr>
<th></th>
<th>DY2</th>
<th>DY3</th>
<th>DY4</th>
<th>DY5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New patients</strong></td>
<td>0</td>
<td>25</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td><strong>Patients with ongoing</strong></td>
<td>0</td>
<td>0</td>
<td>25</td>
<td>50</td>
</tr>
</tbody>
</table>

* Regional Healthcare Partnership Plan

Region 3

538
Starting Point/Baseline: Currently, there are no MHMRA services as the one being proposed.

Rationale: Persons affected with blindness and visual impairment often experience difficulties in several areas of functioning, including behavioral health. The loss of independence associated with visual impairment can be a significant risk factor for depression and substance abuse disorders. Depression is a common mental health problem among individuals who are visually impaired. A recent study found that 7% of persons applying for vision rehab services (over the age of 65) met the criteria for depression, and an additional 27% had sub-threshold depression. The prevalence of depression and other mental disorders may be even greater in young children and middle age adults (i.e., 40–45% have clinical significant depressive symptoms and 20% exhibit moderate to severe anxiety).

The consequences of mental health disorders for adults with visual impairment are far-reaching. They have greater functional disability, morbidity, and mortality. Too often individuals with co-morbid vision loss and depression do not seek services, and when they do, services are limited and often do not address the comorbid vision loss. Depression is also likely to limit rehabilitation outcomes. Given these consequences and the additional barriers faced by visually impaired persons in accessing mental services, it seems imperative to integrate behavioral health services into the vision rehabilitation system.

In the greater Houston area, there are an estimated 74,538 individuals who are blind or severely visually impaired. If we assume that 6% of them have a SPMI, that would imply that 4,472 persons with visual impairment also have a serious and persistent mental illness that interferes with their functioning. This does not include persons struggling with adjustment disorders, anxiety disorders, and depression that, unless treated, will most likely worsen. Given the barriers to accessing care, it is assumed that most of these persons only seek help when in crisis and through the emergency room/hospital system. Persons with visual impairment also have higher rates of co-morbid medical conditions. For example, diabetes is prevalent in 15% of persons with visual impairment.

Project Components: Through the expansion of specialty care services project, we propose to meet all required project components listed below and believe that the selected milestones and metrics relate to the project components.

a) Increase service availability with extended hours
b) Increase number of specialty clinic locations
c) Implement transparent, standardized referrals across the system
d) Conduct quality improvement for project using methods such as rapid cycle improvement

Milestones and Metrics: The goals are consistent with the regional goals and community needs discussed above. Furthermore, the improvement metrics chosen for this project (I-23.1: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking
services) will determine the progress MHMRA is making to meet our stated goals. Specifically, we plan to measure functional status, psychiatric/behavioral symptoms, and patient satisfaction.

**Unique community need identification number the project addresses:** Expansion of the Lighthouse clinic will address the following community needs:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, and elderly
- CN9- High rates of preventable hospital readmissions
- CN0- High rates of preventable hospital admissions

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

- IT 6.1 Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction.
- IT-9.4 Other Outcome Improvement Target: Percent decrease in psychiatric symptoms

**Reasons/rationale for selecting the outcome measure:** Measurement of patient satisfaction is a key indicator of patient-centered care and has been targeted as a quality indicator by national organizations dedicated to improvement in patient outcomes, e.g., the National Council for Quality Assurance. Furthermore, if patients and their family are satisfied with services, then we can assume they are being provided for adequately. On the other hand, if patients are dissatisfied, having an avenue to express their concerns is important for empowering our clients.

**Rationale for selecting the outcome measures:** MHMRA proposes to expand an innovative outpatient option, the Lighthouse clinic, to provide behavioral medicine and behavioral support services to create a safety net for people with impaired vision and co-occurring mental illness who reside in Harris County. This program is a unique clinic with highly skilled clinicians and impaired vision specialists who work together to achieve positive outcomes for people with serious behavioral and/or mental health problems. These services allow for the best opportunity for patient satisfaction as they provide the appropriate level of care for this population.

**Relationship to Other Projects:** This proposed project has activities related to the MHMRA proposal 113180703.2.1 Collaborative Primary and Behavioral Health which also addresses both physical and mental health needs of patients. Several other MHMRA proposed projects are similar to this one in way of provided outpatient behavioral health.

**Relationship to Other Performing Providers’ Projects in the RHP:** TBD

**Plan for Learning Collaborative:** We plan to participate in a region-wide learning collaborative offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.
**Project Valuation:** In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

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

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature.

**Cost-Utility Analysis:**
Our literature review did not reveal QALY estimates specifically for the integration of mental health services and visual impairment. However, we believe there is a close parallel to the integration of mental health and medical care. A review of the scientific literature identified several QALY-based estimates of the cost utility of providing collaborative mental health care in medical settings. We believe there is a parallel in that co-location is not only convenient, it is possible that collaboration among those providing services for the visually impaired and mental health.

One study examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease (Katon, Russo, Lin, Schmittdiel, Ciechanowski, Ludman & Von Korff, 2012). In this study the effect of the intervention was 0.335 QALYs gained.

A second study focusing exclusively on treatment of major depression in the primary practice setting reported an incremental QALY of 0.049 (Rost, Pyne, Dickinson & LoSasso, 2005). In addition, Pyne, Smith, Fortney, Zhang, Williams, & Rost (2003) reported the cost utility of collaborative care for major depression. Their estimates yielded a 0.123 QALY increment over treatment as usual for females and an estimate of a slight, non-significant loss for males (-0.073 QALYs).
An average increment across the three reports can be calculated as \((0.335, 0.049, 0.123, \text{ and } -0.073)\) yields 0.1085 QALYs gained. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

\[
\begin{align*}
100 \text{ (persons served)} \\
0.1085 \text{ (QALY gained)} \\
\times 50,000 \text{ (life year value)} \\
\text{Valuation} = 542,500
\end{align*}
\]

**Cost-effectiveness and Cost Savings:** Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. We did identify benefit-cost studies that were related. Rost and colleagues (2005) reported that their collaborative intervention for major depression produced a significant increment in days free of depression, resulting in 13.4 days between the first and second years of their study; whereas, Simon and colleagues (2012) reported a value of 47.7 additional depression-free days. Rost also reported health plan costs decreased $777.20 (2012 dollars) per treated person. Additional value can be calculated as:

\[
\begin{align*}
100 \text{ (persons served)} \\
x 777.2 \text{ (health plan cost savings)} \\
\text{Cost Savings: Health Plan} = 77,720
\end{align*}
\]

Similarly, Dewa et al. (2009) found that collaborative care saved $545 (2012 US Dollars) per patient in disability benefits. Additional value can be calculated as:

\[
\begin{align*}
100 \text{ (persons served)} \\
x 545 \text{ (disability benefit savings)} \\
\text{Cost Savings: Disability} = 54,500
\end{align*}
\]

**Summary and Total Valuation**

The total value per 100 people served per year can be calculated as:

\[
\begin{align*}
\text{Incremental QALYs} & = 542,500 \\
\text{Health Plan Savings} & = 77,720 \\
\text{Disability Benefit Savings} & = 54,500 \\
\text{Total Valuation} & = 674,720
\end{align*}
\]
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1:</strong> P-21 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects</td>
<td><strong>Milestone 4:</strong> P-21 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects</td>
<td><strong>Milestone 8:</strong> I-23: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td><strong>Milestone 11:</strong> I-23: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.</td>
</tr>
<tr>
<td><strong>Metric 1:</strong> P-21.2 Implement the “raise the floor” improvement initiatives established at the semiannual meeting. Data Source: written documentation</td>
<td><strong>Metric 4:</strong> P-21.2 Implement the “raise the floor” improvement initiatives established at the semiannual meeting. Data Source: written documentation</td>
<td><strong>Metric 8:</strong> I-23.1: Documentation of increased number of visits. Data Source: Registry, EHR, claims or other Performing Provider source. <strong>Goal:</strong> Demonstrate 10% improvement over baseline.</td>
<td><strong>Metric 1:</strong> I-23.1: Documentation of increased number of visits. Data Source: Registry, EHR, claims or other Performing Provider source. <strong>Goal:</strong> Demonstrate 20% improvement over baseline.</td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment:** $143,170.97

**Estimated Incentive Payment:** $162,533.73

**Estimated Incentive Payment:** $710,452.91

**Estimated Incentive Payment:** $683,342.88

**Regional Healthcare Partnership Plan**

**Region 3**

---

**Unique Identifier:** 113180703.1.10  
**RHP PP Reference Number:** 1.9.2  
**Project Components:** 1.9.2 a-d  
**Program Title:** Lighthouse  
**RHP Performing Provider:** Mental Health and Mental Retardation Authority of Harris County  
**TPI:** 113180703

**Related Category 3 Measure(s):**  
**Patient Satisfaction (113180703.3.19) Psychiatric symptoms (113180703.3.29)**

**Year 2**  
**Year 3**  
**Year 4**  
**Year 5**

---

**Unrelated Text:**

- Estimated Incentive Payment:
- Estimated Incentive Payment:
- Estimated Incentive Payment:
- Estimated Incentive Payment:

- Milestone 2: P-19. Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects.  
  **Metric 2:** P-19.1 Number of bi-weekly RHP meetings MHMRA participated in  
  **Data Source:** Documentation of weekly or bi-weekly interactions

- Milestone 3: P-19. Collect baseline data for wait times, backlog, and/or return appointments in specialties  
  **Metric 3:** P-19.1: Establish baseline for performance indicators  
  a. # of days from referral to Lighthouse to the first appointment  
  Data Source: EHR  
  **Goal:** establish baseline  
  **Data Source:** EHR  
  **Goal:** reduce wait time by 5 days

---

**Goal:** Demonstrate 10% improvement over baseline.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$143,170.97</strong></td>
<td><strong>$162,533.73</strong></td>
<td><strong>$710,452.91</strong></td>
<td><strong>$683,342.88</strong></td>
</tr>
</tbody>
</table>

**Milestone 3**: P-11: Launch/expand a specialty care clinic

**Metric 3**: P-11.1: Establish/expand Lighthouse specialty care clinics

**Data Source**: Documentation of new/expanded specialty care clinic

**Number of patients served by specialty care clinic**

**Goal**: Demonstrate 5% improvement over baseline.

**Estimated Incentive Payment**: $143,170.97

**Year 2 Est. Bundle Amount**: $572,683.87

**Goal**: Demonstrate 5% improvement over baseline.

<table>
<thead>
<tr>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$710,452.91</strong></td>
<td><strong>$683,342.88</strong></td>
</tr>
</tbody>
</table>

**Milestone 6**: I-23: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 6**: I-23.1: Documentation of increased number of visits.

**Data Source**: Registry, EHR, claims or other Performing Provider source

**Goal**: Demonstrate 5% improvement over baseline.

**Estimated Incentive Payment**: $162,533.73

**Year 3 Est. Bundle Amount**: $650,134.94

**Goal**: Demonstrate 5% improvement over baseline.

<table>
<thead>
<tr>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$683,342.88</strong></td>
</tr>
</tbody>
</table>

**Milestone 10**: I-X: Improve functional status

**Metric I-X.1**: Percent improvement over baseline of patient functional status scores

**Data Source**: ANSA

**Goal**: 5% increase over baseline

**Estimated Incentive Payment**: $710,452.91

**Year 4 Est. Bundle Amount**: $710,452.91

**Goal**: 10% increase over baseline

**Estimated Incentive Payment**: $683,342.88

**Year 5 Est. Bundle Amount**: $683,342.88

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**: $2,616,614.60
References


1.13 Development of Behavioral Health Crisis Stabilization Services as Alternatives to Hospitalization: Crisis Residential Unit (Cru)

RHP Project Number: 113180703.1.11 TPI: 113180703

Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid.

Intervention(s): MHMRA seeks to expand the Crisis Residential Unit (CRU). This 24-bed unit is specifically designed as a step-down from hospitalization with the goals of reducing the number of bed days required for acute psychiatric hospitalization, reducing hospitalization re-admission rates, and increasing tenure in the community and utilization of outpatient treatment alternatives.

Need for the project: While MHMRA has implemented several crisis alternatives, there still exists a need to address individuals who may no longer be acutely ill, but are still very fragile and/or have a history of frequent hospital readmissions. A step-down residential program of intensive psychosocial treatment coupled with peer supports and after-care options is expected to help those individuals transition more successfully into ongoing treatment options.

Target population: The program will target individuals who have been diagnosed with a serious and persistent mental illness, have frequent admissions to emergency and crisis services. It is anticipated that the program will provide services for about 321 patients in DY 4 and DY5.

Category 1 or 2 expected patient benefits: MHMRA will:

- Enroll 10 additional individuals yearly starting in DY 3 who chronically access PES services.
- 10% reduction from baseline in county jail bookings by DY5
- Reduce both PES and HCPC admissions by 10% decrease from baseline by DY5.

Category 3 outcomes: MHMRA expects to increase patient satisfaction with the communication with providers (as measured by the CAPS) by 10% from baseline by DY5. Also, it is expected there will be a 10% improvement in functional status.
PROJECT DESCRIPTION

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to Develop a behavioral health crisis stabilization service as an alternative to Hospitalization.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

For this project, MHMRA seeks to expand the Crisis Residential Unit (CRU). This 24-bed unit is specifically designed as a step-down from hospitalization with the goals of reducing the number of bed days required for acute psychiatric hospitalization, reducing hospitalization re-admission rates, and increasing tenure in the community and utilization of outpatient treatment alternatives.

Upon successful completion of the program, all residents will be eligible for an after-care program offering two (or more, as needed) weekly aftercare groups that are open to clients and their family members. The groups will be facilitated by a clinician and an alumnus/peer support staff member. The aftercare program will also offer an array of alumni services, including care coordination assistance, access to brief, solution-focused therapy, the opportunity to attend groups in the step-down unit, and group activities (e.g., outings, speakers, especially in the area of vocational opportunities). Furthermore, holiday activities and meals provide opportunities for building support networks, sharing resources, and creating a sense of community.

Goals and Relationship to Regional Goals:

The goal of the program is to assist clients in developing skills to avoid future psychiatric crises. The program will be group-driven and will provide at least two individual therapy sessions per week. The program will utilize cognitive behavioral therapy (an evidence-based practice) as the focal intervention. Symptom management, problem solving, and coping skills will be central to the model; peer support groups will also be offered.
The five-year expected outcome(s):
The five-year expected outcome is a reduction in the need to expand inpatient hospital capacity and consistent linkage of those served into ongoing outpatient treatment programs. We expect that we will be fully operational to serve 321 patients in DY4 and DY5.

Expected Number of Patients Served

<table>
<thead>
<tr>
<th>DY 2</th>
<th>DY 3</th>
<th>DY 4</th>
<th>DY 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>321</td>
<td>321</td>
</tr>
</tbody>
</table>

Rationale:
While MHMRA has implemented several crisis alternatives, there still exists a need to address individuals who may no longer be acutely ill, but are still very fragile and/or have a history of frequent hospital readmissions. A step-down residential program of intensive psychosocial treatment coupled with peer supports and after-care options is expected to help those individuals transition more successfully into ongoing treatment options.

Baseline:
MHMRA does not currently have enough beds in the existing CRU to provide the proposed intervention; therefore, the first priority is to establish a new facility location. The bed capacity at the new location will be 24 beds, with the expectation that the program will be able to serve approximately 320 individuals per year.

Anticipated challenges:
Challenges to implementation include locating and/or renovating appropriate program space and establishing appropriate linkage to ongoing service providers. These challenges will be addressed through stakeholder meetings including supportive housing providers, and through expansion of outpatient behavioral health services for adults with severe psychiatric conditions.

Regional goals:
This project directly meets broad goals identified by the regional needs assessment. First, it improves on existing programs and infrastructure by developing a CRU specific to patients who would benefit from an intensive step-down program. Second, it increases access to specialty care services by providing treatment in a second location in the Houston area. This program is also an inherently patient-centered approach that provides transitional housing and residential care while linking patients to supportive community resources. The proposed program will also complement the regional need to develop a culture of “best practices” whereby the patient/consumer plays a more active role as a stakeholder by completing consumer satisfaction surveys.

Community Need Identification numbers:
CRU addresses the following community needs:

- CN2-Insufficient Access to Behavioral Health
- CN5- Integrated Care for Behavioral Health
- CN12- Improved Access to Patient Education
- CN13- Services for Homeless
This project was chosen with the expectation that community needs and regional goals would be met. The metrics chosen to assess the progress of the program focus on the reduction of readmissions services (I-X.1 Percent decrease in hospitalizations), reduction in ER services (I-X.1 Percent decrease in ER services) and reduction in Jail Bookings (10.1 Percent decrease from baseline in county jail bookings).

**Relationship to other Projects:**
The proposed project is similar to several MHMRA DSRIP proposals, including the expansion of the Interim Care Clinic, the expansion of the Chronic Consumer Stabilization Initiative, and the redesign of the transition from HCPC hospitalization to MHMRA outpatient aftercare. All three proposals seek to expand psychiatric stabilization while reducing inpatient admissions and criminal justice involvement. It is hoped that many of the CRU patients could access these less restrictive and more appropriate care levels in lieu of hospitalization. Also, this project will interface with the expansion of outpatient mental health clinic services, the collaborative primary medical and behavioral health care, and with integrating substance abuse treatment services into mental health services by referring individuals into the appropriate ongoing care alternative.

**Unique community need identification number the project addresses:**
This project will meet broad goals identified by the regional needs assessment. First, it improves on existing programs and infrastructure by filling a void that is unmet by existing psychiatric outpatient clinics and psychiatric emergency services. Second, it increases access to specialty care services by providing these services to a disenfranchised population. The program also offers a preventative, patient-centered approach that provides short-term mental health treatment to those without other resources. By providing such services, the program addresses the community problem of increased demand on criminal justice system. The proposed program will also complement the regional need to develop a culture of “best practices,” whereby the patient plays a more active role as a stakeholder by completing patient satisfaction surveys. The program is expected to reduce the re-incarceration rates of individuals who complete it and is also expected to improve the general functional well-being of its residents (as reflected in ANSA scores) so that they are better able to cope with the stressors of life after discharge.

The proposed program will address the following community needs:

- CN2-Insufficient Access to Behavioral Health
- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions
- CN18- Insufficient access to integrated care programs for behavioral health and physical health conditions

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

1.13 REQUIRED CORE COMPONENTS

a) Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps
   • In progress. MHMRA convenes regularly with Harris County Psychiatric Center in a Joint Quality Council and also attends regular meetings to address patients with high recidivism rates of admissions to HCPC. From that list can be compiled a list of patients who may benefit from this step-down model. MHMRA is also a member of the Harris County Mental Health Needs Council, where issues pertaining to gaps and needs of the community are discussed.

b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.
   • Already completed. MHMRA produces monthly reports on crisis stabilization services available within the agency, and has eligibility criteria and discharge criteria for each service.

c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will lead to a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients (e.g., a minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming Emergency Department settings)
   • In progress. MHMRA convenes regularly with Harris County Psychiatric Center in a Joint Quality Council and also attends regular meetings to address patients with high recidivism rates of admissions to HCPC. From that list can be compiled a list of patients who may benefit from this step-down model.

d) Explore potential crisis residential alternative service models and determine an acceptable and feasible program design for implementation.
   • In progress. MHMRA convenes regularly with Harris County Psychiatric Center in a Joint Quality Council and also attends regular meetings to address patients with high recidivism rates of admissions to HCPC. Also, a review of current literature such as SAMSHA best practices can be reviewed for program design of step-down models.

e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify “lessons learned,” opportunities to scale all or part of
the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations

- To be completed. MHMRA will work with the outcomes department and key stakeholders to review impact and access, identify challenges and refine the intervention strategies.

PROJECT VALUATION

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

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

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature.

Cost-Utility Analysis:
Although no direct studies cost-utility related to psychiatric crisis units were found, a study related to housing for persons living with HIV seemed relevant. A cost-utility analysis by Holtgrave and colleagues (2012) was based on data from the Housing and Health (H&H) Study of unstably housed persons living with HIV in Baltimore, Chicago, and Los Angeles. This study combined outcome data with information on intervention costs to estimate the cost-QALY saved. Results indicated the cost-per-QALY-saved due to housing services was $62,493. They also reported 0.0324 QALY gains due to reduced stress and improved quality of life. For this valuation we focus on housing assistance. Assuming our 100 participants who each participate in crisis residential program, the total value gained from this component would be:
### Cost-effectiveness and Cost Savings:
Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. We identified several studies that found crisis residential units are more cost effective than inpatient hospitals. In 2002, Fenton and team found the mean cost of an acute treatment episode was 44% lower per treatment in a residential crisis program as compared to treatment at a general hospital. They found an average savings of $17,504 (2012 US dollars) per acute care episode per year (treated in residential crisis program rather than a general hospital). Sledge and colleagues (1996) found similar results; they reported that when patients were randomly assigned to crisis respite care rather than hospitalization, respite care costs were $13,585 (2012 US dollars) lower per year. The average cost savings between these two studies was $15,544.

Based on average savings of $15,544 (Fenton et al., 2002) per acute care episode per year (treated in residential crisis program rather than a general hospital):

\[
\begin{align*}
100 \text{ (persons served)} \\ 
0.0324 \text{ (QALY gained)} \\ 
\times 50,000 \text{ (life year value)} \\ 
= 162,000 \text{ QALY Value}
\end{align*}
\]

### Additional Cost Savings:
Two additional studies that looked specifically at services provided by a mobile crisis outreach team (MCOT) found lower expenses compared to treatment as usual. Scott (2000) found that patients using MCOT versus normal care were 27 percentage points less likely to be hospitalized, and had $443 lower expenses. In an Australian study, Hugo, Smout, and Bannister (2002) compared inpatient admission between MCOT users and traditional hospital services emergency services. MCOT patients were 30 percentage points less likely to be admitted.

In addition, a study conducted by Adams and El-Mallakh (2009) investigated crisis stabilization services in Kentucky. The authors determined that the cost for one day of care of crisis stabilization was $195 (in 2012 US dollars), while the cost for a day at the state hospital was $488 (in 2012 US dollars) – a savings of $293 per day. Although the Adams and El-Mallakh (2009) study is relevant, the study design did not randomize the patients to ensure comparability between CSU and hospitalization; therefore it was not used to value this project.

### Summary and Total Valuation:
This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention. The total expected value of benefits, based on the average of the Fenton article and the Sledge et al. article, is $1,554,400. The Fenton et al. study’s QALY-based estimate was $162,000. The total valuation is $1,716,400 per 100 people served per year.
<table>
<thead>
<tr>
<th>Unique Identifier: 113180703.1.1</th>
<th>RHP PP Reference Number: 1.13.1</th>
<th>Project Components: 1.13.1a, 1.13.1b, 1.13.1c, 1.13.1d, 1.13.1e</th>
<th>Program Title: CRISIS RESIDENTIAL UNIT (CRU) EXPANSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td>TPI: 113180703</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s): Patient Satisfaction Functional Status</td>
<td>Category 3 IT Identifiers: 6.1 10.1</td>
<td>Improvement Target: Percent improvement over baseline of patient satisfaction scores Improvement of functional status</td>
<td>1.13.1: Develop and Implement Crisis Stabilization</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Milestone 1: P-2.</strong> Review mapping and gap analysis of current crisis system</td>
<td><strong>Milestone 3: P-4.</strong> Hire and train staff to implement the CRU clinic</td>
<td><strong>Milestone 8: P-6.</strong> Evaluate and continuously improve crisis services</td>
<td><strong>Milestone 13 P-6.</strong> Evaluate and continuously improve crisis services</td>
</tr>
<tr>
<td><strong>Metric 1: P.2.1</strong> Produce a written analysis of community needs for crisis services. <strong>Goal:</strong> complete within DY 2. <strong>Data Source:</strong> Written plan</td>
<td><strong>Metric 3: P-4.1</strong> Number of staff hired and trained <strong>Goal:</strong> At least 50% of staff hired and trained. <strong>Data Source:</strong> Human Resource records</td>
<td><strong>Metric 8: P-6.1</strong> Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles <strong>Goal:</strong> Establish quality improvement goal based on quarterly reports. <strong>Data Source:</strong> Quarterly Reports</td>
<td><strong>Metric 1: P-6.1</strong> Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles <strong>Goal:</strong> Review quality improvement goal based on quarterly reports. <strong>Data Source:</strong> Quarterly Reports</td>
</tr>
<tr>
<td>Estimated Incentive Payment: $2,204,685.94</td>
<td>Estimated Incentive Payment: $969,458.73</td>
<td>Estimated Incentive Payment: $1,035,970.32</td>
<td>Estimated Incentive Payment: $1,000,937.51</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>Milestone 2: P-3.</strong> Develop implementation plans for CRU</td>
<td><strong>Milestone 4: P-5.</strong> Review and refine administration of operational protocols and clinical guidelines for a CRU program</td>
<td><strong>Milestone 9: I-10.</strong> Jail Bookings</td>
<td><strong>Milestone 14: I-10.</strong> Jail Bookings</td>
</tr>
<tr>
<td><strong>Metric 2: P-3.1</strong> Produce an updated, data-driven, written action plan for development of CRU based on gap analysis and needs.</td>
<td><strong>Metric 4: P-5.1</strong> Goal: Completion of policies and procedures.</td>
<td><strong>Metric 9: I-10.1</strong> Goal: A 5% decrease from baseline in county jail bookings</td>
<td><strong>Metric 1: I-10.1</strong> Goal: A 10% decrease from baseline in county jail bookings</td>
</tr>
<tr>
<td><strong>Goal:</strong> Complete within DY2</td>
<td><strong>Data Source:</strong> Written policy and operations manuals.</td>
<td><strong>a. Numerator:</strong> Percent of CRU patients booked/arrested</td>
<td><strong>Data Source:</strong> MHMRA records and Harris County Jail records.</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Written plan</td>
<td></td>
<td><strong>b. Denominator:</strong> The number of patients receiving CRU</td>
<td></td>
</tr>
</tbody>
</table>

<p>| <strong>Estimated Incentive Payment:</strong> $2,204,685.94 | <strong>Estimated Incentive Payment:</strong> $969,458.73 | <strong>Estimated Incentive Payment:</strong> $1,035,970.32 | <strong>Estimated Incentive Payment:</strong> $1,000,937.51 |</p>
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
| N/A | Milestone 5: I-X. Psychiatric Emergency Service (PES) Readmissions and Inpatient Public Hospital Admissions  
**Metric 5: I-X.1**  
Number of inpatient admissions at PES/HCPC for CRU  
**Goal:** Establish baseline  
**Data Source:** Psychiatric Emergency Service (PES) records are part of the MHMRA electronic record. Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records | Milestone 10: I-X. Psychiatric Emergency Service (PES) Readmissions  
**Metric 1: I-X.1**  
Number of inpatient admissions at PES  
**Goal:** Decrease the percentage of ER services by 5% from baseline  
a. Numerator: Number of patients receiving CRU services admitted to PES  
b. Denominator: Number of patients receiving CRU services  
**Data Source:** MHMRA and public psych hospital records | Milestone 15: I-X. Psychiatric Emergency Service (PES) Readmissions  
**Metric 1: I-X.1**  
Number of inpatient admissions at PES  
**Goal:** Decrease the percentage of ER services by 10% from baseline  
a. Numerator: Number of patients receiving CRU services admitted to PES  
b. Denominator: Number of patients receiving CRU services  
**Data Source:** MHMRA and public psych hospital records |
| N/A | Estimated Incentive Payment: $969,458.73 | Estimated Incentive Payment: $1,035,970.32 | Estimated Incentive Payment: $1,000,937.51 |
| Milestone 11: I-X. Reduction in Inpatient Public Hospital Admissions  
**Metric 1: I-X.1** | Milestone 16: I-X. Reduction in Inpatient Public Hospital Admissions  
**Metric 1: I-X.1** |
<table>
<thead>
<tr>
<th>Unique Identifier: 113180703.1.11</th>
<th>RHP PP Reference Number: 1.13.1</th>
<th>Project Components: 1.13.1a, 1.13.1b, 1.13.1c, 1.13.1d, 1.13.1e</th>
<th>Program Title: CRISIS RESIDENTIAL UNIT (CRU) EXPANSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td></td>
<td>TPI: 113180703</td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s): Patient Satisfaction Functional Status</td>
<td>Category 3 IT Identifiers: 6.1 10.1</td>
<td>Improvement Target: Percent improvement over baseline of patient satisfaction scores Improvement of functional status</td>
<td>1.13.1: Develop and Implement Crisis Stabilization</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Milestone 6: P-X. Locate, remodel, and furnish a facility for CRU Metric 6: P-X.1 B5 Documented location site and permits. Goal: Data Source: Project Plan, licenses and permits</td>
<td>Number of inpatient admissions at HCPC for CRU patients Goal: Decrease inpatient admissions rate by 5% from baseline a. Numerator: Number of patients receiving CRU admitted to HCPC b. Denominator: Number of patients receiving CRU services Data Source: MHMRA and public psych hospital records</td>
<td>Number of inpatient admissions at HCPC for CRU patients Goal: Decrease inpatient admissions rate by 10% from baseline a. Numerator: Number of patients receiving CRU admitted to HCPC b. Denominator: Number of patients receiving CRU services Data Source: MHMRA and public psych hospital records</td>
<td>Number of inpatient admissions at HCPC for CRU patients Goal: Decrease inpatient admissions rate by 10% from baseline a. Numerator: Number of patients receiving CRU admitted to HCPC b. Denominator: Number of patients receiving CRU services Data Source: MHMRA and public psych hospital records</td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan | Region 3 | 556
<table>
<thead>
<tr>
<th>Unique Identifier: 113180703.1.11</th>
<th>RHP PP Reference Number: 1.13.1</th>
<th>Project Components: 1.13.1a, 1.13.1b, 1.13.1c, 1.13.1d, 1.13.1e</th>
<th>Program Title: CRISIS RESIDENTIAL UNIT (CRU) EXPANSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td>TPI: 113180703</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s): Patient Satisfaction Functional Status</td>
<td>Category 3 IT Identifiers: 6.1 10.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement Target: Percent improvement over baseline of patient satisfaction scores Improvement of functional status</td>
<td>1.13.1: Develop and Implement Crisis Stabilization</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td><strong>Milestone 7: I-10.</strong> Jail Bookings Metric 7: I-10.1 Establish a baseline of CRU consumers’ jail bookings/admissions Goal: Data Source: MHMRA and county jail records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

| N/A | **Estimated Incentive Payment:** $969,458.73 |
| N/A | N/A |

**Year 2 Est. Bundle Amount:** $4,409,371.88
**Year 3 Est. Bundle Amount:** $4,847,293.64
**Year 4 Est. Bundle Amount:** $5,179,851.61
**Year 5 Est. Bundle Amount:** $5,004,687.53

**TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY:** $19,441,204.66
REFERENCES


OakBend Medical Center

Pass 1
**Project Option 1.3.1:** Implement and Utilize Disease Management Registry Functionality  
**Performing Provider:** OakBend Medical Center (OBMC)/127303903  
**Unique Project ID:** 127303903.1.1

- **Provider:** OakBend Medical Center is a stand-alone hospital authority that was established in October 1947 under the original name of Polly Ryon Memorial Hospital. OakBend Medical Center has grown to a hospital system, still governed by a hospital authority. It has expanded to two hospital locations, two diagnostic imaging centers, an outpatient surgical center, a free-standing Emergency Room and a Medical Group with 7 clinic locations. The Medical Group consists of Family Practice, OB/Gyn, Infectious Disease, Podiatry, Orthopedic, Cardiology and Interventional Cardiology. OakBend was able to provide more than $29,412,325 in charity care through September during FY 2012.

<table>
<thead>
<tr>
<th><strong>Volume Statistics - FY2012</strong></th>
<th><strong>Patient Payor Mix – YTD 9/12</strong></th>
<th><strong>Patient Demographics</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions- 5,453</td>
<td>Self-Pay- 13.8%</td>
<td>Hispanic- 39.6%</td>
</tr>
<tr>
<td>Births (babies delivered)- 1,080</td>
<td>Medicaid and CHIP- 19.5%</td>
<td>African American- 16.7%</td>
</tr>
<tr>
<td>Emergency visits- 23, 433</td>
<td>Medicare- 40.1%</td>
<td>Caucasian- 34.6%</td>
</tr>
<tr>
<td></td>
<td>Other Funding- N/A</td>
<td>Asian- 2.0</td>
</tr>
<tr>
<td></td>
<td>Commercial Insurance- 26.6</td>
<td>Other- 6.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>American Indian- 0.4</td>
</tr>
</tbody>
</table>

- **Intervention(s):** This project will develop a chronic disease registry to use county wide to ensure providers and clinical staff with access to determine clinical outcomes and to identify physician, psychological and emotional needs of the chronically ill patients that we care for each day.

- **Need for the project:** The purpose of this project, as well as the other Category one (1) and two (2) projects, is to identify and target the at risk chronic disease(s) population and to move towards decreasing their inappropriate utilization patterns. Once identified, we plan to educate and encourage them to self-manage their healthcare, thus improving their quality of life as well as their inappropriate utilization of healthcare services.

- **Target population:** All patients that seek their medical care through any of the OakBend Medical Center system entities, who will benefit from this and other projects. We plan to target patients with Medicaid, CHIP and Self-Pay, especially those with chronic disease(s).

- **Category 1 or 2 expected patient benefits:** Our DY3 goal is to expand the Registry functionality to 30% of the Performing Provider’s sites with increases in enrollment in DY4 and DY5.

Over the course of the project, OakBend expects approximately 137,208 patient visits as a result of this project as follows:

45,736 patient visits in DY 3
91,472 patient visits in DY 4

137,208 patient visits in DY 5

OakBend expects approximately 33.3% of these patients will be Medicaid or indigent.

- **Category 3 outcomes**: IT 3.2 – Our goal is to reduce CHF 30 day readmissions by 2% of baseline in DY4 and 5% of baseline by DY5.

**Title**: Implement and Utilize Disease Management Registry Functionality

**Unique RHP Project Identification Number**: 127303903.1.1

**Performing Provider Name/TPI**: OakBend Medical Center (OBMC) / 127303903

**Project Description: 1.3 / 1.3.1**

Providers in the OakBend Medical Group (OMG) and the Fort Bend Family Health Care Center (FBFHC) will receive monthly registry reports on their patients with CHF, COPD, Diabetes and ESRD. OBMC will develop and implement a registry in conjunction with FBFHC and specific home health providers. The Home Health (HH) providers will be selected based on quality outcome measures and hospital readmission indicators.

OBMC will develop curriculum and educational training in conjunction with FBFHC in the use of a disease management registry. In addition, OBMC will develop curriculum and educational training in conjunction with the specific HH companies that have disease management programs, as well as develop curriculum and educational training in conjunction with the OBMC nephrologists and dialysis centers to provide education to all pre-renal and current dialysis patients on a quarterly basis, at a minimum. OBMC will provide a meeting space for any educational offerings that are provided in collaboration with selected community-based HH agencies, nephrologists, dialysis centers or the FBFHC in conjunction with Community Health Workers (CHWs). The personal contact and encouragement of the CHW may assist in influencing and promoting the patients’ willingness to become more involved in the management of their health care through the utilization of available resources.

**Goal(s) and relationship to Regional goal(s):**

**Project goals:**

OBMC will create, expand and/or integrate longitudinal databases and population registry of health care utilization and services for patients with common chronic diseases of Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Diabetes and End Stage Renal Disease (ESRD) to decrease the number of readmissions to the hospital.

This project meets the following Region 3 goals:

This project addresses the RHP’s goal to “[d]evelop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.”
Challenges and how addressed:

Working through time constraints allowed for each patient/physician interaction when caring for the chronic disease population; development and implementation of a disease-specific registry; developing a well-planned-out information support system with the ability for a robust data monitoring and outcomes management component; promoting and incentivizing the patient population to utilize available services; hiring and training of staff; managing non-compliant patients; space allocation for CHW; establishing a more focused coordination between the hospital and FBFHC with the CHW and other entities to achieve the shared goal of decreased readmissions. OBMC will address these challenges on a case-by-case basis, in large part by developing and providing education for patients in conjunction with the disease registry. The CHW will work in collaboration with each patient and their PCP / SCP to implement data entry and follow through of patients with disease specific diagnosis.

5-year expected outcome for provider and patients:

Improved health outcomes for patients with common chronic diseases targeted by the disease management registry, including CHF, COPD, diabetes, and ESRD, as measured by this project’s Category 1 improvement milestones and Category 3 improvement targets. We plan to track all patients registered in the data base to assist with forming a relationship with their PCP/SCP. We will also add and track new patients with any of the above chronic diseases as they are identified. We will monitor these patients for improved compliance thus improved chronic disease outcomes.

Starting Point/Baseline:

Baseline data:

OBMC does not currently have a disease management registry and has no patients enrolled.

Time period for baseline:

1/1/12 to 6/30/12

Rationale:

Reasons for selecting the project option:

One of the biggest issues facing appropriate management of chronic care conditions is the lack of coordination of care. By implementing a disease management registry OBMC can monitor the care utilization of patients with chronic diseases to determine whether they have had adequate follow-up and preventative care. CHWs can contact patients who are not receiving adequate care and work with partners like FBFHC to coordinate care delivery and ensure there is no duplication of services. Additionally, having this information will allow OBMC to track the long-term clinical success of tertiary care vendors HH and refer patients to those vendors who have demonstrated success in helping patients manage their chronic conditions. This will ultimately allow for better health outcomes and an increased quality of life for these patients.

Project components:

The core components of this project will be:

a) Enter patient data into unique chronic disease registry.

b) Use registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.
c) Use registry reports to develop and implement targeted QI plan. Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

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

- One of OakBend’s milestones in Year 4 is to implement a continuous quality improvement plan by establishing meetings with other RHP providers.

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

- CN.9: High rates of preventable hospital readmissions
- CN-11: High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease

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

The ability to track the clinical utilization of patients with certain diagnosis codes and specific chronic conditions will be a new and significant tool for OBMC to both coordinate the delivery of care with its clinical partners and monitor the long-term effectiveness of its treatments. The result will be a collaboration that improves the health outcomes for OBMC’s patients and reduces the cost of care by delivering services in an efficient and coordinated manner. Furthermore, a better coordination of care will result in a better patient experience and more informed autonomous patient decisions.

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

IT-3.2 Congestive Heart Failure 30-Day Readmission Rate (Standalone Measure)

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

If the project is successful, then it will result in more effective management of chronic conditions, which in turn will result in the reduction of unnecessary readmissions. Congestive heart failure is an exemplar diagnosis for which effective disease management has been shown to reduce unnecessary hospital admissions. Therefore, the reduction in CHF admissions will be a reasonable metric by which to judge the effectiveness of this project.
**Relationship to Other Projects:**
How project supports, reinforces, and enables other projects:

This project will lay a foundation for, and reinforce the clinical effectiveness of OBMC’s other DSRIP projects, including:

- 127303903.2.1: Redesign to Improve Patient Experience—Implement Consumer Assessment System
- 127303903.2.2: Establish Patient Care Navigation Program
- 127303903.1.3: Expand Specialty Care Capacity
- 127303903.1.2: Increase Training of Primary Care Workforce

**Relationship to Other Performing Providers’ Projects in the RHP:**
List of other providers in the RHP that are proposing similar projects:

[Blank per Anchor’s instructions.]

**Plan for Learning Collaborative:**

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. Specifically relating to this project, we plan to use these learning collaboratives to discuss with other providers in the region methods of ensuring that overall regional CHF admission and readmission rates are decreased, rather than CHF patient populations merely being diverted from one provider to another.

**Project Valuation:**

**Approach for valuing project:**

OBMC values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing this project, OBMC took into account the extent to which the implementation of a disease management registry would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to implement the project.

**Rationale/justification for valuation:**

The implementation of a disease management registry will significantly improve health outcomes for patients with chronic diseases, improve patient experience, and ultimately result in the reduction of healthcare costs; therefore, OBMC took these factors into account when considering the appropriate incentive payment value for this project.
### Related Category 3 Outcome Measure(s): 127303903.3.1 IT-3.2 Congestive Heart Failure 30-Day Readmission Rate

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Milestone 1** P-1: Identify one or more target patient populations diagnosed with selected chronic disease(s) (e.g. diabetes, CHF, COBP, etc.) or with Multiple Chronic Conditions (MCCs). **Baseline/Goal:** OBMC does not currently have a disease management registry and has no patients enrolled. **Metric 1 P-1.1:** Documentation of patients to be entered into the registry. **Data Source:** Performing provider records/documentation.

**Milestone 1 Estimated Incentive Payment (maximum amount):** $440,580 |

**Milestone 2** P-2: Review current registry capability and assess future needs. **Metric 1 P-2.1:** Documentation of review of current registry capability and assessment of future registry needs. **Goal:** Project planning and creation of an accurate assessment of future needs. **Data Source:** EHR systems and/or other performing provider documentation.

**Milestone 2 Estimated Incentive Payment:** | $480,649 |

**Milestone 3** P-3: Develop cross-functional team to evaluate registry program. **Metric 1 P-3.1:** Documentation of personnel (clinical, IT, administrative) assigned to evaluate registry program. **Goal:** To establish the necessary personnel to effectively and successfully implement the project. **Data Source:** Team roster and minutes from team meetings.

**Milestone 3 Estimated Incentive Payment:** | $480,649 |

**Milestone 4** P-4: Implement/expand a functional disease management registry. **Metric 2 P-4.1:** Registry functionality is available in 30% of the Performing Provider’s sites and includes an expanded number of targeted diseases or clinical conditions. **Goal:** To implement a function registry in 30% of identified sites. **Data Source:** Documentation of adoption, installation, upgrade, or migration.

**Milestone 4 Estimated Incentive Payment:** | $482,046 |

**Milestone 5** I-15: Increase the percentage of patients enrolled in the registry. **Baseline/Goal:** 2% improvement in enrollment in the registry over baseline of DY3. **Metric 1 I-15.1:** Percentage of patients in the registry; metric may vary in terms of measuring absolute targets versus increasing the proportion of patients meeting a specific criteria (e.g., medical home patients, patients with a targeted chronic condition).

(Approximately 1,484 patient visits) **Data Source:** Registry or EHR

**Milestone 5 Estimated Incentive Payment:** | $482,046 |

**Milestone 6** P-13: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data will be collected with simple, interim measurement systems, and will be based on self-reported data and sampling that is sufficient for the purposes of improvement.

**Milestone 6 Estimated Incentive Payment:** | $398,212 |

**Milestone 7** I-15: Increase the percentage of patients enrolled in the registry. **Baseline/Goal:** 5% improvement in enrollment in the registry over baseline of DY3. **Metric 1 I-15.1:** Percentage of patients in the registry; metric may vary in terms of measuring absolute targets versus increasing the proportion of patients meeting a specific criteria (e.g., medical home patients, patients with a targeted chronic condition).

(Approximately 3,712 patient visits) **Data Source:** Registry or EHR

**Milestone 7 Estimated Incentive Payment:** | $398,212 |

**Milestone 8** P-13: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data will be collected with simple, interim measurement systems, and will be based on self-reported data and sampling that is sufficient for the purposes of improvement.

**Milestone 8 Estimated Incentive Payment:** | $398,212 |
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment:</strong> $440,580</td>
<td><strong>Metric 1:</strong> P-13.1 Number of new ideas, practices, tools, or solutions tested. <strong>Goal:</strong> To continuously monitor and control the quality of the project. <strong>Data Source:</strong> Brief description of the idea, practice, tool, or solution tested each week, and summarized at quarterly intervals.</td>
<td><strong>Metric 1:</strong> P-13.1 Number of new ideas, practices, tools, or solutions tested. <strong>Goal:</strong> To continuously monitor and control the quality of the project. <strong>Data Source:</strong> Brief description of the idea, practice, tool, or solution tested each week, and summarized at quarterly intervals.</td>
<td><strong>Metric 1:</strong> P-13.1 Number of new ideas, practices, tools, or solutions tested. <strong>Goal:</strong> To continuously monitor and control the quality of the project. <strong>Data Source:</strong> Brief description of the idea, practice, tool, or solution tested each week, and summarized at quarterly intervals.</td>
<td><strong>Metric 1:</strong> P-13.1 Number of new ideas, practices, tools, or solutions tested. <strong>Goal:</strong> To continuously monitor and control the quality of the project. <strong>Data Source:</strong> Brief description of the idea, practice, tool, or solution tested each week, and summarized at quarterly intervals.</td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment: $480,649</td>
<td>Milestone 6 Estimated Incentive Payment: $482,046</td>
<td>Milestone 8 Estimated Incentive Payment: $398,212</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount (add incentive payments amounts from each milestone): $881,161</td>
<td>Year 3 Estimated Milestone Bundle Amount: $961,299</td>
<td>Year 4 Estimated Milestone Bundle Amount: $964,094</td>
<td>Year 5 Estimated Milestone Bundle Amount: $796,425</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5):</strong> $3,602,979</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Project Option:** 1.2.2 Increase the number of primary care providers (PCP’s)

**Performing Provider:** OakBend Medical Center (OBMC)/127303903

**Unique Project ID:** 127303903.1.2

- **Provider:** OakBend Medical Center is a stand-alone hospital authority that was established in October 1947 under the original name of Polly Ryon Memorial Hospital. OakBend Medical Center has grown to a hospital system, still governed by a hospital authority. It has expanded to two hospital locations, two diagnostic imaging centers, an outpatient surgical center, a free-standing Emergency Room and a Medical Group with 7 clinic locations. The Medical Group consists of Family Practice, OB/Gyn, Infectious Disease, Podiatry, Orthopedic, Cardiology and Interventional Cardiology. OakBend was able to provide more than $29,412,325 in charity care through September during FY 2012.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix – YTD 9/12</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions- 5,453</td>
<td>Self-Pay- 13.8%</td>
<td>Hispanic- 39.6%</td>
</tr>
<tr>
<td>Births (babies delivered)- 1,080</td>
<td>Medicaid and CHIP- 19.5%</td>
<td>African American- 16.7</td>
</tr>
<tr>
<td>Emergency visits- 23, 433</td>
<td>Medicare- 40.1%</td>
<td>Caucasian- 34.6</td>
</tr>
<tr>
<td></td>
<td>Other Funding- N/A</td>
<td>Asian- 2.0</td>
</tr>
<tr>
<td></td>
<td>Commercial Insurance- 26.6</td>
<td>Other- 6.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>American Indian- 0.4</td>
</tr>
</tbody>
</table>

- **Intervention(s):** The shortage of PCP’s has contributed to increased wait times in hospitals, community clinics, and other care settings. This we feel discourages some individuals from seeking care due to the limited resources. This will increase access and capacity and help create an organized structure of PCP’s, clinicians, and staff.

- **Need for the project:** The expansion of PCP’s will promote and encourage patients to access appropriate level of care leading to better clinical outcomes for the community. The purpose of this project, and other Category one (1) and two (2) projects, is to increase availability of PCP’s to improve quality of life as well as decrease inappropriate utilization of healthcare services.

- **Target population:** This project addresses the RHP’s goal to increase access to primary and specialty care services, with a focus on underserved populations. To ensure patients receive the most appropriate care for their condition. We plan to target patients with Medicaid, CHIP and Self-Pay, especially those with chronic disease(s).

- **Category 1 or 2 expected patient benefits:** OBMC will expand the number of Primary Care Physicians (PCPs) on our current physician panel by two physicians in the Third (3rd) year and by a total of four (4) by year five (5).

  Over the course of the project, OakBend expects approximately **137,208** patient visits as a result of this project as follows:

  **45,736** patient visits in DY 3
91,472 patient visits in DY 4
137,208 patient visits in DY 5

OakBend expects approximately 33.3% of these patients will be Medicaid or indigent.

- **Category 3 outcomes: IT 3.2** – The increase in access to primary care physician services will decrease the number of admissions for diseases like CHF, that can be adequately managed on an outpatient basis.

**Title:** Increase Training of Primary Care Workforce

**Unique RHP Project Identification Number:** 127303903.1.2

**Performing Provider Name/TPI:** OakBend Medical Center (OBMC) / 127303903

**Project Description: 1.2 / 1.2.2**

Texas has a growing shortage of primary care doctors and nurses due to the needs of an aging population, a decline in the number of medical students choosing primary care, and thousands of aging baby boomers who are doctors and nurses looking towards retirement. The shortage of primary care workforce personnel in Texas is a critical problem that we have the opportunity to begin addressing under this Waiver. It is difficult to recruit and hire primary care physicians. The shortage of primary care providers has contributed to increased wait times in hospitals, community clinics, and other care settings. Expanding the primary care workforce will increase access and capacity and help create an organized structure of primary care providers, clinicians, and staff. Moreover, this expansion will strengthen an integrated health care system and play a key role in implementing disease management programs. A greater focus on primary care will be crucial to the success of an integrated health care system.

**Goal(s) and relationship to Regional goal(s):**

**Project goals:**

OBMC will expand the number of Primary Care Physicians (PCPs) on our current physician panel by two physicians in the second (2nd) year and by a total of four (4) by year five (5). We will also plan to increase the support staff to compliment the additional physicians. In addition, OBMC will provide training to these new physicians to integrate them into the community.

This project meets the following Region 3 goals:

This project addresses the RHP’s goal to “[i]ncrease access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.”

**Challenges and how addressed:**

- Recruiting primary care physicians OBMC will address this challenge by emphasizing to potential providers the benefits of living and working in a vibrant and growing area such as
Fort Bend County. The cost of living is lower than many places in the nations with low crime and no drastic seasonal changes. The shortage of PCP’s has contributed to increased wait times in hospitals, community clinics, and other care settings. This we feel discourages some individuals from seeking care due to the limited resources. This will increase access and capacity and help create an organized structure of PCP’s, clinicians, and staff.

5-year expected outcome for provider and patients:
Increased access to primary health care services for patients in the community.

Starting Point/Baseline:
Baseline data: OBMC currently has 15 primary care physicians in the community, but will need at least four more over the next five years in order to meet the demand for primary care services in the community.
Time period for baseline: 1/1/12 to 6/30/12

Rationale:
Reasons for selecting the project option:
Currently OBMC provides high-quality, affordable care to residents of Fort Bend County regardless of their ability to pay. However, access to primary care appointments is limited. As a result, many patients are cared for exclusively in the Emergency Department (ED). This setting is not designed to provide comprehensive assessment, disease-specific education, preventative care and coordination. Therefore OBMC chose to implement this project in order to address the need for primary care in the community.

Unique community need identification number the project addresses:
CN.1: Inadequate access to primary care

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
This will considerably improve OBMC’s primary care capacity, as evidenced by a 25% increase in primary care encounters for OakBend Medical Group (OMG) and clinic sites compared to the current baseline. Additionally, this project will increase OBMC’s ability to provide appropriate care in a timely manner and in the correct setting. This will enable OBMC to treat more patients in this type of setting, where they will receive education including disease-specific, as well as preventative care and screenings.

Related Category 3 Outcome Measure(s):
IT-2.1 Congestive Heart Failure Admission Rate (CHF)

Reasons/rationale for selecting the outcome measure(s):
The increase in access to primary care physician services will decrease the number of admissions for diseases that can be adequately managed like CHF.
Relationship to Other Projects:
How project supports, reinforces, and enables other projects:
This project will lay a foundation for, and reinforce the clinical effectiveness of, OBMC’s other DSRIP projects, including:
127303903.1.3: Expand Specialty Care Capacity
127303903.1.1: Implement and Utilize Disease Management Registry Functionality
127303903.2.2: Establish Patient Care Navigation Program

Relationship to Other Performing Providers’ Projects in the RHP:
List of other providers in the RHP that are proposing similar projects:
[Blank per Anchor’s instructions.]

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

Project Valuation:
Approach for valuing project:
OBMC values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.
In valuing this project, OBMC took into account the extent to which the expansion of primary care providers would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to implement the project.
Rationale/justification for valuation:
The expansion of primary care providers will promote and encourage patients to access care which will lead to better clinical outcomes for the community. OBMC took these potential effects into account when considering the appropriate incentive payment value for this project.
| 127303903.1.2 | 1.2.2 | 1.2.2 | **INCREASE TRAINING OF PRIMARY CARE WORKFORCE**
OAKBEND MEDICAL CENTER | 127303903 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td>127303903.3.2</td>
<td>IT-2.1</td>
<td><strong>Congestive Heart Failure Admission Rate (CHF)</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Milestone 1 P-1 Conduct a primary care gap analysis to determine workforce needs.</td>
<td>Milestone 2 I-12 Recruit/hire more trainees/graduates to primary care positions in Performing Provider facilities.</td>
<td>Milestone 3 I-12 Recruit/hire more trainees/graduates to primary care positions in Performing Provider facilities.</td>
<td>Milestone 4 I-12 Recruit/hire more trainees/graduates to primary care positions in Performing Provider facilities.</td>
</tr>
<tr>
<td><strong>Metric 1 P-1.1:</strong> Gap assessment of workforce shortages. Submission of completed assessment.</td>
<td><strong>Baseline/Goal:</strong> Hire 1 new primary care MD or nurse practitioner over DY2 baseline.</td>
<td><strong>Baseline/Goal:</strong> Hire 2 new primary care MDs or nurse practitioners over DY2 baseline.</td>
<td><strong>Baseline/Goal:</strong> Hire 3 new primary care MDs or nurse practitioners over DY2 baseline.</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Assessment results.</td>
<td><strong>Metric 1 I-12.1:</strong> Percent change in number of graduates/trainees accepting positions in the Performing Provider’s facilities over baseline.</td>
<td><strong>Metric 1 I-12.1</strong> Percent change in number of graduates/trainees accepting positions in the Performing Provider’s facilities over baseline.</td>
<td><strong>Metric 1 I-12.1</strong> Percent change in number of graduates/trainees accepting positions in the Performing Provider’s facilities over baseline.</td>
</tr>
<tr>
<td><strong>Goal:</strong> To conduct a gap assessment and determine a baseline for future years.</td>
<td><strong>Data Source:</strong> Documentation, such as HR documents compared to class lists.</td>
<td><strong>Data Source:</strong> Documentation, such as HR documents compared to class lists.</td>
<td><strong>Data Source:</strong> Documentation, such as HR documents compared to class lists.</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment (maximum amount): <strong>$570,163</strong></td>
<td>Milestone 2 Estimated Incentive Payment: <strong>$622,017</strong></td>
<td>Milestone 3 Estimated Incentive Payment: <strong>$623,825</strong></td>
<td>Milestone 4 Estimated Incentive Payment: <strong>$515,334</strong></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount (add incentive payments amounts from each milestone): <strong>$570,163</strong></td>
<td>Year 3 Estimated Milestone Bundle Amount: <strong>$622,017</strong></td>
<td>Year 4 Estimated Milestone Bundle Amount: <strong>$623,825</strong></td>
<td>Year 5 Estimated Milestone Bundle Amount: <strong>$515,334</strong></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over DYs 2-5): **$2,331,339**
Project Option: 1.9.1 Expand Specialty Care Capacity
Performing Provider: OakBend Medical Center (OBMC) / 127303903
Unique Project ID: 127303903.1.3

• Provider: OakBend Medical Center is a stand-alone hospital authority that was established in October 1947 under the original name of Polly Ryon Memorial Hospital. OakBend Medical Center has grown to a hospital system, still governed by a hospital authority. It has expanded to two hospital locations, two diagnostic imaging centers, an outpatient surgical center, a free-standing Emergency Room and a Medical Group with 7 clinic locations. The Medical Group consists of Family Practice, OB/Gyn, Infectious Disease, Podiatry, Orthopedic, Cardiology and Interventional Cardiology. OakBend was able to provide more than $29,412,325 in charity care through September during FY 2012.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix–YTD 9/12</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions- 5,453</td>
<td>Self-Pay- 13.8%</td>
<td>Hispanic- 39.6%</td>
</tr>
<tr>
<td>Births (babies delivered)- 1,080</td>
<td>Medicaid and CHIP- 19.5%</td>
<td>African American- 16.7</td>
</tr>
<tr>
<td>Emergency visits- 23,433</td>
<td>Medicare- 40.1%</td>
<td>Caucasian- 34.6</td>
</tr>
<tr>
<td></td>
<td>Other Funding- N/A</td>
<td>Asian- 2.0</td>
</tr>
<tr>
<td></td>
<td>Commercial Insurance- 26.6</td>
<td>Other- 6.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>American Indian- 0.4</td>
</tr>
</tbody>
</table>

• Intervention(s): OBMC will expand the number of Specialty Care Physicians (SCPs) on our current physician panel by the addition of Obstetrics and Gynecology, Cardiology/Interventional Cardiology, Otolaryngology and Orthopedic specialty services.

• Need for the project: The increase in access to specialty physician services across a wide range of clinical specialties will result in a decrease in preventable readmissions because effective disease management and access to care reduce the incidence of acute conditions. The purpose of this project, and other Category one (1) and two (2) projects, is to increase availability of SCP’s to improve quality of life as well as decrease inappropriate utilization of healthcare services.

• Target population: This project addresses the RHP’s goal to increase access to primary and specialty care services, with a focus on underserved populations. To ensure patients receive the most appropriate care for their condition. We plan to target patients with Medicaid, CHIP and Self-Pay, especially those with chronic disease(s).

• Category 1 or 2 expected patient benefits: Our goal is to increase our current referral pattern in each disease-specific category by five (5%) percent in the third (3rd) year and by a total of fifteen (15%) percent by year five (5).

    Over the course of the project, OakBend expects approximately 137,208 patient visits as a result of this project as follows:

    45,736 patient visits in DY 3
91,472 patient visits in DY 4

137,208 patient visits in DY 5

OakBend expects approximately 33.3% of these patients will be Medicaid or indigent.

- **Category 3 outcomes**: IT 3.2 – Increase the number of specialty providers, clinic hours and/or procedure hours available for the most highly impacted medical specialties.

**Title**: Expand Specialty Care Capacity

**Unique RHP Project Identification Number**: 127303903.1.3

**Performing Provider Name/TPI**: OakBend Medical Center (OBMC) / 127303903

**Project Description: 1.9 / 1.9.1**

OBMC will expand the number of Specialty Care Physicians (SCPs) on our current physician panel by the addition of Obstetrics and Gynecology, Cardiology/Interventional Cardiology, Otolaryngology and Orthopedic specialty services. In order to assist in appropriate utilization of the additional physician specialists, OBMC will implement an electronic specialty referral process and train its providers on its use.

OBMC wishes to implement this project to increase the capacity to provide specialty care services and the availability of targeted specialty providers to better accommodate the high demand for specialty care services so that patients have increased access to specialty services. Federal funding (Medicare Direct Graduate Medical Education or DGME) for residency training is capped at 1996 levels for the direct support of graduate medical education. The cap only supports a third of the costs of 4,056 of the 4,598 actual positions in Texas, leaving the residency programs to cover the cost of two-thirds of the 4,056 positions and the full cost of 542 positions. Texas is currently over its Medicare cap by 13%. Residency programs require 3 to 8 years of training, depending on the specialty. Medicare funding only covers years 1 through 3. In 2011, Texas had more than 550 residency programs, offering a total of 6,788 positions. Only 22% (1,494) of these were first-year residency positions. According to the Coordinating Board, conservative estimates indicate that the cost to educate a resident physician for one year is $150,000. Hence the State and the Fort Bend Community specifically, has a need for specialists.

**Goal(s) and relationship to Regional goal(s):**

**Project goals:**

Our goal is to increase our current referral pattern in each disease-specific category by five (5%) percent in the second (2nd) year and by a total of fifteen (15%) percent by year five (5).

This project meets the following Region 3 goals:

This project addresses the RHP’s goal to “[i]ncrease access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.”
Challenges and how addressed:

Recruitment of physician specialists; training staff on new referral procedures. OBMC will address the challenge of physician recruitment by emphasizing to potential specialist providers the benefits of living and working in a vibrant and growing area such as Fort Bend County. The cost of living is lower than many places in the nations with low crime and no drastic seasonal changes. The shortage of PCP’s and SCP’s has contributed to increased wait times in hospitals, community clinics, and other care settings. This we feel discourages some individuals from seeking care due to the limited resources. This will increase access and capacity and help create an organized structure of PCP’s, SCP’s, clinicians, and staff.

5-year expected outcome for provider and patients:

Increase access to specialty care, as measured by project milestones and metrics. We plan to accomplish this by use of a Community Health Worker and a Community Health Coordinator. These two positions will assist patients as they access the ECC (Emergency Care Center) either for outpatient treatment in an ECC setting or upon discharge from an observation or inpatient hospitalization. They will help these patients via coordination and establishment of referral patterns to PCP’s and SCP’s as indicated and medically appropriate.

Starting Point/Baseline:
Baseline data:
OBMC has begun the review of referral patterns to determine the clinical areas where specialists are needed.
Time period for baseline:
1/1/12 to 6/30/12

Rationale:
Reasons for selecting the project option:
This will increase OBMC’s ability to provide appropriate care in a timely manner and in the correct setting. This will enable OBMC to treat more patients in this type of setting, where they will receive education including disease-specific, as well as preventative care and screenings. In addition, the project will considerably improve OBMC’s communication between the primary care and other healthcare consultants, through improvement of our physician referral line and electronic specialty referral process.

Project components:

We will meet the core components of this project which include:

a) Organizational integration and prioritization of patient experience.
b) Identify high impact/most impacted specialty services and gaps in care and coordination.
c) Increase the number of residents/trainees choosing targeted shortage specialties.
d) Design workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention).
e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the
project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

P-1. Milestones and Metrics:
The following milestones and metrics were chosen for the OakBend Expand Specialty Care Capacity Project based on the core components and the needs of the target population:

Process Milestones and Metrics: P-1 (P-1.1); P-2 (P-2.1); P-20 (P-20.1)
Improvement Milestones and Metrics: I-22 (I-22.1)

Unique community need identification number the project addresses:
CN.2: Inadequate access to specialty care

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
This project would represent a new initiative for OBMC to streamline the delivery of care by recruiting targeted physician specialists in the community rather than referring to specialists in neighboring areas. This provides increased access for patients in the community and allows for better and more efficient coordination of care.

Related Category 3 Outcome Measure(s):
IT-3.1 All Cause 30-Day Readmission Rate

Reasons/rationale for selecting the outcome measure(s):
The increase in access to specialty physician services across a wide range of clinical specialties will result in a decrease in preventable readmissions because effective disease management and access to care reduce the incidence of acute conditions.

Relationship to Other Projects:
How project supports, reinforces, and enables other projects:
This project will lay a foundation for, and reinforce the clinical effectiveness of, OBMC’s other DSRIP projects, including:

1.10 Enhance Performance Improvement and Reporting Capacity
2.2 Expand Chronic Care Management Models
2.4 Redesign to Improve Patient Experience
2.5 Redesign for Cost Containment
127303903.1.1: Implement and Utilize Disease Management Functionality
127303903.1.2: Training of Primary Care Workforce

Relationship to Other Performing Providers’ Projects in the RHP:
List of other providers in the RHP that are proposing similar projects:
[Blank per Anchor’s instructions.]

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

**Project Valuation:**

**Approach for valuing project:**

OBMC values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing this project, OBMC took into account the extent to which the expansion of specialty care capacity would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to implement the project.

**Rationale/justification for valuation:**

The expansion of specialty care capacity will promote and encourage patients to access care which will lead to better clinical outcomes for the community. OBMC took these potential effects into account when considering the appropriate incentive payment value for this project.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>127303903.3</td>
<td>127303903.3.3</td>
<td>IT-3.1</td>
<td>All Cause 30-Day Readmission Rate</td>
</tr>
</tbody>
</table>

### Milestone 1
**Milestone 1** [P-1]: Conduct specialty care gap assessment based on community need.

**Baseline/Goal:** Complete gap assessment.

**Metric 1** P-1.1: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2).

**Data Source:** Needs assessment.

**Milestone 1 Estimated Incentive Payment (maximum amount):** $518,330

### Milestone 2
**Milestone 2** [P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties.

**Baseline/Goal:** Educate primary care providers on availability of specialists to whom referrals can be made.

**Metric 1** P-2.1 Training of staff and providers on referral guidelines, process and technology.

**Data Source:** Log of specialty care personnel trained and curriculum for training.

**Milestone 2 Estimated Incentive Payment:** $282,735

### Milestone 3
**Milestone 3** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties.

**Baseline/Goal:** 1 specialist MD or NP over baseline; or 1% increase in yearly procedure hours over baseline; or increase of 10 clinic hours per month over baseline.

**Metric 1** I-22.1: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties. (Approximately 800 patient visits)

**Data Source:** HR documents or other documentation demonstrating employed/contracted specialists.

**Milestone 3 Estimated Incentive Payment:** $283,556

### Milestone 4
**Milestone 4** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties.

**Baseline/Goal:** According to the gap assessment, increase number and continue to educate primary care providers on availability of additional specialists to whom referrals can be made. Increase specialty providers by 1 and/or clinic hours or procedure hours by 2 each month over DY2.

**Metric 1** I-22.1: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties. (Approximately 1,600 patient visits)

**Data Source:** HR documents or other documentation demonstrating employed/contracted specialists.

**Milestone 4 Estimated Incentive Payment:** $234,242

### Milestone 5
**Milestone 5** P-20: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data will be collected with simple, interim measurement systems, and will be used to evaluate progress.

**Baseline/Goal:** Expand number and continue to educate primary care providers on availability of additional specialists to whom referrals can be made. Increase specialty providers by 2 and/or clinic hours or procedure hours by 4 each month over DY2.

**Metric 1** I-22.1: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties.

**Data Source:** HR documents or other documentation demonstrating employed/contracted specialists.

**Milestone 5 Estimated Incentive Payment:** $234,242

### Milestone 6
**Milestone 6** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties.

**Baseline/Goal:** Expand number and continue to educate primary care providers on availability of additional specialists to whom referrals can be made. Increase specialty providers by 2 and/or clinic hours or procedure hours by 4 each month over DY2.

**Metric 1** I-22.1: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties.

**Data Source:** HR documents or other documentation demonstrating employed/contracted specialists.

**Milestone 6 Estimated Incentive Payment:** $234,242
### EXPAND SPECIALTY CARE CAPACITY

**Related Category 3 Outcome Measure(s):**
- 127303903.1.3
- 1.9.1
- 1.9.1 A-E

**OAKBEND MEDICAL CENTER**

**Year 2**
(10/1/2012 – 9/30/2013)

- Specialist providers, clinic hours and/or procedure hours in targeted specialties.

  **Data Source:** HR documents or other documentation demonstrating employed/contracted specialists.

- Milestone 3 Estimated Incentive Payment: $282,735

**Year 3**
(10/1/2013 – 9/30/2014)

- Based on self-reported data and sampling that is sufficient for the purposes of improvement.

  **Baseline/Goal:** 2 specialist MDs or NPs over baseline; or 2% increase in yearly procedure hours over baseline; or increase of 15 clinic hours per month over baseline.

  **Metric 1** P-20.1 Number of new ideas, practices, tools, or solutions tested.

  **Data Source:** Brief description of the idea, practice, tool, or solution tested each week, and summarized at quarterly intervals.

- Milestone 5 Estimated Incentive Payment: $283,556

**Year 4**
(10/1/2014 – 9/30/2015)

- Based on self-reported data and sampling that is sufficient for the purposes of improvement.

  **Baseline/Goal:** 3 specialist MDs or NPs over baseline; or 3% increase in yearly procedure hours over baseline; or increase of 20 clinic hours per month over baseline.

  **Metric 1** P-20.1 Number of new ideas, practices, tools, or solutions tested.

  **Data Source:** Brief description of the idea, practice, tool, or solution tested each week, and summarized at quarterly intervals.

- Milestone 7 Estimated Incentive Payment: $234,242

**Year 5**
(10/1/2015 – 9/30/2016)

- Based on self-reported data and sampling that is sufficient for the purposes of improvement.

  **Baseline/Goal:** 3 specialist MDs or NPs over baseline; or 3% increase in yearly procedure hours over baseline; or increase of 20 clinic hours per month over baseline.

- Milestone 7 Estimated Incentive Payment: $234,242

---

**Year 2 Estimated Milestone Bundle Amount (add incentive payments amounts from each milestone):** $518,330

**Year 3 Estimated Milestone Bundle Amount:** $565,470

**Year 4 Estimated Milestone Bundle Amount:** $567,114

**Year 5 Estimated Milestone Bundle Amount:** $468,485

---

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5):** $2,119,399
Rice Medical Center

Pass 1
Project Option 1.1.2 - Expand existing primary care capacity

Unique RHP Project Identification number: 212060201.1.1
Performing Provider/TPI: Rice/212060201

- **Provider:** Rice Medical Center is a 25-bed critical access hospital with Trauma IV designation in Eagle Lake, Texas serving a, 1100 square mile area and a population of approximately 20,000.

- **Intervention(s):** Rice intends to expand the availability of family practice obstetric services in the East Bernard Rural Health Clinic (“RHC”) and Rice Medical Center service areas by hiring a family practice obstetrician (“FP/OB”) to work in the clinic. This project will entail identifying a larger space for the East Bernard RHC in which the FP/OB will practice and scheduling the FP/OB to provide after-hours services (noon-8pm shifts) during the week.

- **Need for the project:** Wharton County, where the East Bernard Clinic is located, is populated by 10,964 women, 3,874 of which are between the ages of 15 and 44 years old (reproductive age). Approximately 30-40% of those women reside within the service area of the East Bernard clinic. The service area does not currently provide local FP/OB women’s health coverage, requiring women in need of services to travel significant distances to access care.

- **Target population:** The target population includes female patients who reside within the East Bernard Clinic’s service area and currently have very limited access to OB services in the community (one part-time FP/OB and one family practice physician). The East Bernard Clinic treated approximately 665 women of reproductive age in 2012, and approximately 133 of those were Medicaid/uninsured (20%). Those existing patients are intended to benefit from the addition of the FP/OB, as well as other low-income women in the surrounding community without access to OB/Gyn services currently. Wharton County has a population of 41,000, with a 28% uninsured rate (11,500 uninsured in Wharton County). One in four patients treated in the East Bernard clinic were women of reproductive age, and if the same statistic applies more generally, that means there are almost 2900 uninsured women in Wharton County needing access to an FP/OB, and at least 1000 of those women reside in the clinic’s service area.

- **Category 1 or 2 expected patient benefits:** The project seeks to provide local access to a family practice physician specializing in OB/Gyn services in DY3, and extended after-hours access to the FP/OB in DY4, allowing working women and school-age girls the opportunity to access the FP/OB in the evenings. Rice expects the FP/OB to provide 1000 encounters to women requiring OB/Gyn services in his/her first full year of practice. In DY5, the FB/OB will increase that number by 40%, and provide at least 1400 encounters to women requiring OB/Gyn services.

- **Category 3 outcomes:** IT-6.1 – By DY4, Rice will improve East Bernard Clinic’s patient satisfaction scores in the domain of timely access to care, appointments, and information by 5% over the baseline established in DY3 through the addition of the FP/OB to the East Bernard Clinic. By DY5, Rice seeks a 10% improvement in the same domain of patient satisfaction scores over baseline.
Project Option 1.1.2 - Expand existing primary care capacity

**Unique RHP Project Identification number:** 212060201.1.1  
**Performing Provider/TPI:** Rice/212060201

**Project Description:**  
Rice proposes to expand the availability of family practice obstetric services.

We intend to expand the availability of family practice obstetric services in the East Bernard RHC and Rice service areas by hiring a physician to provide these services. With increased access to women’s family practice and OB services, the health outcomes for women and their infants will improve in the short- and long-term, as will the delivery system costs of providing care.

Specifically, Rice is going to build a new clinic in East Bernard to replace the existing RHC, as the current lease is up and Rice is no longer able to maintain the space. The East Bernard clinic is the only source of primary care in the East Bernard area. In conjunction with opening the new (and improved) East Bernard clinic, Rice intends to hire an FP/OB to provide services to women, and will pilot having the FP/OB to work after-hours (noon-8pm shifts) in order to allow working women and school-age girls to receive care. The increase in patient encounters provided by the FP/OB will be separate and in addition to the increased patient volume targeted by the clinic’s overall expansion.

**Goals and Relationship to Regional Goals:**  
Expand the existing capacity of primary care in the East Bernard community to better accommodate the needs and increase the availability of care for this patient population allowing them to receive the right care at the right time in the right setting. The specific goals of this project include:

- Recruit an FP/OB provider to the East Bernard Clinic
- Require the FP/OB to provide after-hours appointments during the week, increasing access for working women and school-age girls.
- Increase the volume of women patients treated by the FP/OB over DY3 in DYs 4 and 5.

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

**Project Goals:**

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

Challenges:
Rice expects the biggest challenge of this project to be recruiting the appropriate candidate willing and able to provide this type of care to an underserved community. Rice intends to approach this challenge with innovative solutions, including creating attractive benefits for a provider to relocate to this rural area.

5-Year Expected Outcome for Provider and Patients:
Rice expects women’s overall health screening, treatment, and management to improve with the addition of the FP/OB primary care physician to the new East Bernard clinic. Patients will enjoy improved access to appointments and specialty care in the area of obstetrics. These improvements should yield longer-term benefits, including a reduction in low birth weights, earlier detection of breast, cervical, and other types of cancers affecting women, and reproductive education and control for women under the FP/OB’s care.

Starting Point/Baseline:
The women of (northern) Wharton County do not currently have access to a full-time FP/OB in the (East Bernard) area, and have only access to a primary care physician providing those services in the RHC that the East Bernard Clinic will replace. The clinic treated 665 unique patients in 2012 who were women of reproductive age, and approximately 23% of those were Medicaid/uninsured. Wharton County has a population of 41,000, with a 28% uninsured rate (11,500 uninsured in Wharton County). One in four patients treated in the East Bernard clinic were women of reproductive age, and if the same statistic applies more generally, that means there are almost 2900 uninsured women in Wharton County needing access to an FP/OB, and at least 1000 of those women reside in the clinic’s service area.

Rationale:
Wharton County is a federally designated Health Professional Shortage Area when it comes to primary care for low income residents. The low-income community members residing in East Bernard and the boundaries of the Rice Hospital District are underserved by physicians providing OB services as well, on top of which population growth trends and the recent 33% reduction in local OB providers support the need for an additional OB provider in the area.
Wharton County is populated by 10,964 women, 3,874 of which are between the ages of 15 and 44 years old. A percentage of those women reside within the service area of the East Bernard clinic. The service area currently is without FP/OB women’s health coverage without significant travel.

Wharton County has a lower rate of mammography screening than the statewide average, which is one of many issues this project seeks to address. More than 8% of infants born in Wharton County suffer from low birth weight, which is another condition that can be positively affected by access to an FP/OB. Finally, Wharton County’s teen birth rate is higher than the statewide rate, which an FP/OB can address through sex education and preventative measures for teens in the community. Increasing access to this type of primary care is imperative to preserving and improving women’s health in the community.

**Project Components:**
This project will address the core requirements of this project option in the following ways:

a) Expand primary care clinic space:
   - The new East Bernard clinic will have expanded square footage, with space dedicated to the practice women’s health care (including an exam room specifically equipped to allow annual wellness visits, prenatal visits, and visits for specialized gynecological/obstetric needs).

b) Expand primary care clinic hours:
   - The East Bernard clinic will be providing at least 9 additional hours of availability per week as part of the clinic’s expansion, and the FP/OB specifically will operate after-hours for FP/OB services during the week (noon-8pm shifts), in order to provide care to working women and school-age children.

c) Expand primary care clinic staffing:
   - The East Bernard clinic will enjoy expanded staffing, in that the FP/OB will be a new addition, and equipped to handle specialty and primary care for women and girls in the community (this is in additional to the primary care provider expansion that Rice will accomplish as part of its project 212060201.1.6).

**Milestones and Metrics:**
The following milestones and metrics were chosen for the expansion of the existing primary care capacity project based on the core components and the needs of the target population:
Process Milestones and Metrics: P-1 (P-1.1); P-4 (P-4.1); P-5 (P-5.1)
Improvement Milestones and Metrics: I-12 (I-12.1, I-12.2)

**Unique community needs identification numbers:**
Ties to Region 3 unique community needs: CN.1, CN.3, CN.7, CN.8, CN.9, CN.12

**Related Category 3 Outcome Measure(s):**
OD-6 Patient Satisfaction, IT-6.1(1) - Patient satisfaction with getting timely care, appointments, and information

**Reasons/rationale for selecting the outcome measures:**
Rice chose this Category 3 Outcome domain because one of the main goals in recruiting the new FP/OB to the area is to improve patient satisfaction with their access to primary and specialty care. If patients feel they are able to receive timely care, appointments, and information, they are more likely to seek treatment and maintain best health practices under the supervision of their physician.

**Relationship to other Projects:**
This project relates to the following projects that Rice is submitting: Reduce Inappropriate Use of the ED and Chronic Disease Outreach. This project will tie in with giving patients improved access to primary care so they will be less inclined to use the ED for non-emergent treatment, and will allow additional patient touches that are always beneficial to patients at risk for or managing chronic diseases.

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

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

**Project Valuation:**
The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project was valued Rice’s most valuable because it most clearly accomplishes the goals of the Waiver by increasing access to primary and specialty care through additional staffing, hours, and space) and a reduction in expensive use of the ED and preventable hospital admissions for treatment.

This provider will be available to all women of reproductive age in the Region and can provide education, screening, diagnosis, and treatment for reproductive issues. The project will take significant investment in recruiting, training, and paying the new provider, as well as providing...
additional perks or benefits to incentivize a provider to relocate to a rural area like Colorado County and work after-hours during the week.
<table>
<thead>
<tr>
<th>212060201.1.1</th>
<th>1.1.2</th>
<th>1.1.2 A-C</th>
<th>EXPAND EXISTING PRIMARY CARE CAPACITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice</td>
<td>212060201</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s):</strong></td>
<td><strong>IT-6.1</strong></td>
<td><strong>Percent improvement over baseline of patient satisfaction scores</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1** [P-1]: Establish additional/expand existing/relocate primary care clinics.

**Metric 1** [P-1.1]: Rice will relocate the existing RHC and expand capacity by hiring an additional physician.

Baseline/Goal: Currently limited space with no FP/OB physician

Data source: Plans and documentation evidencing the relocation of the East Bernard clinic to a larger space accommodating the additional physician

Milestone 1 Estimated Incentive Payment: $67,486

**Milestone 2** [P-5]: Train/hire additional care providers and staff.

**Metric 1** [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites.

Baseline/Goal: Currently the RHC does not have an FP/OB provider, Rice will recruit and hire an FP/OB to provide services in the East Bernard clinic.

Data Source: Physician contract and/or HR documentation

Milestone 2 Estimated Incentive Payment: $73,624

**Milestone 3** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours.

**Metric 1** [P-4.1]: Increased number of hours at primary care clinic over baselines.

Baseline/Goal: Rice will require the FP/OB to provide after-hours services (noon-8pm shift in all likelihood) during the week, which are currently not offered

Data Source: Clinic documentation

Milestone 3 Estimated Incentive Payment: $73,838

**Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1** [I-12.1]: Documentation of increased number of visits

Baseline/Goal: Rice expects the FP/OB to provide 1000 encounters to OB/Gyn services in his/her first full year of practice. In DY5, the FB/OB will increase that number by 40%, and provide at least 1400 encounters to women requiring OB/Gyn services.

Data Source: EHR/Registry

Milestone 4 Estimated Incentive Payment: $60,996

**Year 2 Estimated Milestone Bundle Amount:** $67,486

**Year 3 Estimated Milestone Bundle Amount:** $73,624

**Year 4 Estimated Milestone Bundle Amount:** $73,838

**Year 5 Estimated Milestone Bundle Amount:** $60,996
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>212060201.3.1</th>
<th>IT-6.1</th>
<th>Expand Existing Primary Care Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $275,944
Rice Medical Center
Pass 3
Pass 3

Project Option 1.7.1: Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region - Implement Telehealth & Telemedicine in Colorado County

Unique RHP Project Identification Number: 212060201.1.2
Performing Provider Name/TPI: Rice TPI/212060201

- **Provider**: Rice Medical Center is a critical access hospital located in Eagle Lake, Colorado County, TX. The county population served by Rice is approximately 21,000. Rice also serves East Bernard in Wharton County, home to approximately 2,000 residents.

- **Intervention(s)**: Rice intends to develop the use of telemedicine in its Colorado County facilities and in schools to increase and improve access to specialty care services for community stakeholders. Rice intends to use this program in 4 distinct ways: (1) to increase local patients’ access to specialty consultations without having to travel to Houston; (2) to obtain tele-psychiatric consults to aid in the timely transfer of psychiatric patients presenting in Rice’s ED to the appropriate care settings; (3) to attract businesses to Colorado County by using the telemedicine project to engage in the practice of occupational medicine; and (4) to aid school nurses in treating children by linking them electronically with primary care providers in the community.

- **Need for the project**: The availability of telemedicine services allows community members access to specialties they may not otherwise access. Many residents of the County cannot afford to travel for healthcare, do not have access to transportation, or cannot afford to take time off from work or school. According to the Region’s County Health Rankings, Colorado County has a higher rate of premature death, poor physical health days, low birth weight, and adult obesity than the statewide average. Each of these statistics can be tied to conditions requiring specialty care that may not be available in Colorado County, supporting Rice’s initiative to increase access to needed care and decrease the burden on patients by implementing a telemedicine program.

- **Target population**: The target population of this project is patients in Colorado County who have needs for specialty care but currently have difficulty accessing it. Rice treats approximately 3650 patients per year through the hospital, and approximately 4200 patients through its Eagle Lake Clinic (located in Colorado County), each of whom may benefit from the telemedicine program (depending on the specialist participants Rice is able to recruit). Of those patients who may benefit from the program, 61% of the hospital patients are Medicaid/uninsured and 45% of the clinic patients are Medicaid/uninsured.

- **Category 1 or 2 expected patient benefits**: Rice expects an increase in Colorado County residents’ access to and use of specialty care because distance will no longer be a limiting factor. Additionally, Rice expects the transfer time for psychiatric patients presenting in the ED to be significantly reduced and Rice’s occupational medicine capabilities to increase. Rice will implement telehealth and telemedicine capabilities in DY3, during which time Rice expects to provide at least 36 telemedicine consults to patients requiring access to specialty care. Rice expects to increase the number of
consults by 200% over DY3 in DY4 (resulting in approximately 108 consults), and to double the number of DY4 consults in DY5 (resulting in approximately 216 consults). Rice will improve the volume of patient

- **Category 3 outcomes:** IT 6.1 Rice chose the patient satisfaction outcome measure because it ties in directly with the goal of this project, which is to allow patients and their PCPs to have access to specialists for consultations and referrals.
Project Option 1.7.1: Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region- Implement Telehealth & Telemedicine in Colorado County

Unique RHP Project ID: 212060201.1.2
Performing Provider Name/TPI: Rice / 212060201

Project Description:

Rice intends to develop the use of telemedicine in its Colorado County facilities and in schools to increase and improve access to specialty care services for community stakeholders. Rice intends to use this program in 4 distinct ways: (1) to increase local patients’ access to specialty consultations without having to travel to Houston; (2) to obtain tele-psychiatric consults to aid in the timely transfer of psychiatric patients presenting in Rice’s ED to the appropriate care settings; (3) to attract businesses to Colorado County by using the telemedicine project to engage in the practice of occupational medicine; and (4) to aid school nurses in treating children by linking them electronically with primary care providers in the community. While patients in Colorado County have identified needs for specialty care, there is not enough demand to support recruitment of specialists. In the absence of the telemedicine services, patients must either wait until their conditions become chronic necessitating hospitalizations or spend long hours commuting to Houston for such care.

Goals and Relationship to Regional Goals:

Rice’s specific goals for this project include:

- Identifying areas of specialty where Rice’s patients show a need for consultations/care
- Improving local access to specialist consultations from providers in urban areas through the use of telemedicine

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

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

Challenges:

Expected challenges include: (1) educating providers and patients to embrace technological advantages of telemedicine; (2) training providers to use the technology; (3) establishing a network of specialists willing to work with Rice’s providers (including psychiatrists); and, (4) implementing the necessary technology to make the program possible in the clinics. The project will address these challenges by using DYs 2-3 to plan and deploy the infrastructure for the program, and then proceeding in DY 4-5 to make the best use of the new telemedicine services.

5 year expected outcome:

Rice expects an increase in Colorado County residents’ access to and use of specialty care because distance will no longer be a limiting factor. Specifically, Rice expects to set a baseline of telemedicine visits in DY3 when it establishes the program, and then to increase the number of visits by a total of 20% by the end of DY5.

Additionally, Rice expects the transfer time for psychiatric patients presenting in the ED to be significantly reduced and Rice’s occupational medicine capabilities to increase.

Starting Point/Baseline:

Patients in the Colorado County community do not currently have access to telemedicine services, and have to travel to Houston to access many specialty services, which involves at least an hour of travel each way for patients and/or their families. Rice treats approximately 4200 patients annually through its Eagle Lake Clinic and approximately 3650 patients annually through its hospital facility (understanding there is significant overlap in these populations), and many of these patients are expected to benefit from the telemedicine capabilities by the end of the Waiver. Of those patients, 45-50% are Medicaid/uninsured.

Rationale:

Telemedicine is currently unavailable in the Rice Hospital District service area. The availability of telemedicine services allows community members access to specialties they may not otherwise access. Many residents of the County cannot afford to travel for healthcare, do not have access to transportation, or cannot afford to take time off from work or school.

According to the Region’s County Health Rankings, Colorado County has a higher rate of premature death, poor physical health days, low birth weight, and adult obesity than the statewide average. Each of these statistics can be tied to conditions requiring specialty care that may not be available in Colorado County, supporting Rice’s initiative to increase access to needed care and decrease the burden on patients by DY5 through implementing a telemedicine program.
Project Components:

This project will address the following core requirements in the following ways:

1. Rice will enable Colorado County residents through the hospital and its clinics to access consultations with medical and surgical specialists, as well as other practitioners when needed. This will entail creating a network of providers and establishing a system for consultations and referrals out of the system. Specialties and/or conditions targeted by this program are likely to include Family Practice, Psychiatry, Cardiology, Neurology, Pediatrics, and/or Obstetrics.

2. Rice will engage in quality improvement with regard to its telemedicine project by measuring the project’s efficacy and impact on the Colorado County community in DY4, assessing where improvements can be made going forward. Quality improvements over the life of the project may include: targeting new and/or different specialties, reaching out to the patient community to expand the use of the services, or expanding the use of telemedicine beyond Colorado County.

Ties to unique Region community needs:

CN.1- Inadequate access to primary care
CN.2- Inadequate access to specialty care
CN.3- Inadequate access to behavioral health care

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

This is an entirely new initiative for Rice Medical Center and the surrounding community.

Related Category 3 Outcome Measure(s):

OD-6 Patient Satisfaction, P1 – Project planning, P2 – Establish baseline rates

IT 6.1(3), Percent improvement over baseline of patient satisfaction in patient’s rating of doctor access to specialist

Reasons/Rational for selecting the outcome measure:

This outcome measure ties in directly with the goal of this project, which is to allow patients and their primary care physicians to have access to specialists for consultations and referrals.

Relationship to other Projects:

This project relates to the following projects that Rice is submitting: Increasing access to health care, primary and specialty. This project will tie in with giving patients improved access to primary health care and a variety of special health care services so they will be less inclined to use the ED for non-emergent treatment and will allow patient access to beneficial services,
especially those patients without access to healthcare for any variety of reasons and those patients at risk for managing chronic diseases.

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

**Plan for Learning Collaborative:**

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

**Project Valuation:**

The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. The value of this project derives from the investment necessary to implement it (equipment, provider training, outreach to specialists in Texas), its expected impact on the community (increased access to specialists with reduced effort, more efficient transfer of psychiatric patients out of the ED, and increased occupational medicine capabilities), and its expected impact on the institutional cost of providing care (earlier intervention by appropriate practitioner should lead to better outcomes and lower costs). Psychiatric patients often languish in EDs or other inappropriate care settings, so this project will impact a traditionally underserved population of patients. Rural patients requiring specialist consults in order to receive treatment also face barriers in accessing care, which this project seeks to bridge. Assuming that Rice is successful in recruiting a comprehensive group of specialists to participate in the telemedicine program, this project will touch a broad base on Rice’s patient community and completely redesign the care delivery system in Colorado and neighboring counties. For these reasons, this project is very valuable to Rice.
<table>
<thead>
<tr>
<th>Milestone 1 [P-1]: Conduct needs assessment to identify needed specialties that can be provided via telemedicine.</th>
<th>Milestone 2 [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need.</th>
<th>Milestone 4 [P-X]: Assess efficacy of processes in place and recommend process improvements to implement, if necessary.</th>
<th>Milestone 6 [I-12]: Increase number of telemedicine visits for each specialty identified as high need.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1 [P-1.1]: Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel.</strong>&lt;br&gt;Goal: Rice will use its access to patient records and community data to assess which specialty services are most needed in the community, and work on creating a network of those specialists. Rice will additionally seek psychiatrists to participate in the telemedicine program in the hospital’s ED.&lt;br&gt;Data source: Documentation of the assessment</td>
<td><strong>Metric 1 [P-4.1]: Documentation of the program materials, including implementation plan, vendor agreements/contracts, staff training, and HR documents.</strong>&lt;br&gt;Goal: Rice will implement a telemedicine program in its hospital that uses a network of specialty providers for conditions/services identified in the specialty needs assessment as lacking in the community. Rice expects to provide approximately 36 telemedicine consults during DY3.&lt;br&gt;Data source: Program materials</td>
<td><strong>Metric 1 [P-X.1]: Review data about the rate and volume of consults by specialty to determine if changes need to be made (i.e. wider network of specialists, targeting different specialties, etc.) Baseline/goal: Rice’s goal is to measure the impact of the project thus far, and the to identify practices that are yielding positive results, and areas of improvement.</strong>&lt;br&gt;Data source: Report of findings and recommendations</td>
<td><strong>Metric 1 [I-12.1]: Number of telemedicine visits</strong>&lt;br&gt;Goal: Rice will double the number of telemedicine visits for its patients needing consultations in the identified specialties from DY4s number by the end of DY5 (estimated to result in a total of 216 consults).&lt;br&gt;Data Source: Rice EHR</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $469,403</td>
<td>Milestone 2 Estimated Incentive Payment: $207,089.50</td>
<td>Milestone 4 Estimated Incentive Payment: $193,283.50</td>
<td>Milestone 6 Estimated Incentive Payment: $287,164</td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan  
Region 3  
595
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>IT-6.1(3)</th>
<th>Percent improvement over baseline of patient satisfaction in patient’s rating of doctor access to specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Implementation plan, vendor agreements/contracts, staff training, and HR documents. Goal: Rice will create a telehealth program to implement in local public schools in Colorado County, which will assist school nurses in treating children without the children needing to leave the school setting. Data Source: Documentation of plan and implementation in the schools. Milestone 3 Estimated Incentive Payment: $207,089.50</td>
<td></td>
<td>total in DY4. Data Source: Rice EHR Milestone 5 Estimated Incentive Payment: $193,283.50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $469,403</th>
<th>Year 3 Estimated Milestone Bundle Amount: $414,179</th>
<th>Year 4 Estimated Milestone Bundle Amount: $386,567</th>
<th>Year 5 Estimated Milestone Bundle Amount: $287,164</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $1,557,313</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Project Option 1.1.1: Establish more primary care clinics - Expand primary care clinics

Unique RHP Project Identification Number: 212060201.1.3
Performing Provider Name/TPI: Rice TPI/212060201

• **Provider:** Rice Medical Center is a critical access hospital located in Eagle Lake, Colorado County, TX. The county population served by Rice is approximately 21,000. Rice also serves the town of East Bernard in Wharton County with a population of approximately 2,000.

• **Intervention(s):** Rice will establish a primary care clinic in Wallis, Texas. This clinic will be operated by a mid-level provider supervised by a physician. Rice believes that this clinic will allow patients in the Wallis area to receive care appropriate to the medical conditions they experience.

• **Need for the project:** The residents of Wallis have no local primary care services. Wallis is located in Austin County (neighbor to Colorado County, where Rice Medical Center is located), and its ratio of patients to primary care physicians is almost 5 times that of the statewide average (6758:1 and 1378:1, respectively). The population of Austin County, including Wallis, suffers from a higher rate of poor physical and mental health days and preventable hospital stays than the statewide average. There is logically a connection between the paucity of primary care providers in Austin County and the high incidence of poor health in the community. Rice believes that opening a local clinic will go far towards improving the health of the Wallis community.

• **Target population:** The target population of this project is the Medicaid/eligible and uninsured residents of Wallis, Texas and other patients within a ten-mile radius who have no local primary care services. The clinic will be especially tailored to treat patients with no third party source of payment and with inadequate funding to self-pay for their primary care services. The population of Wallis according to the 2010 census was 1252 people, and the population of Austin County in 2011 was 28,665 people. Rice estimates that the catchment area of the clinic will include at least 2500 people. The uninsured rate in Austin County is 24%, thus the target population includes at least 600 unique patients.

• **Category 1 or 2 expected patient benefits:** Rice expects this project to result in improved patient health outcomes due to easier access to primary care that is geographically proximate to the patients who need this care. Specifically, Rice expects the clinic to be open to treat patients in DY3. During DY3 Rice expects the Wallis Clinic to provide approximately 750 encounters ("baseline"), with a targeted 33% increase in encounters over baseline in DY4 (estimated 1000 encounters total), and with a targeted 100% increase in encounters over baseline in DY5 (estimated 1500 encounters total).

• **Category 3 outcomes:** IT 6.1 – Rice chose the patient satisfaction outcome measure because it ties in directly with the goal of this project, which is to increase the overall health of residents of the Wallis community by making primary care services available in their community. Specifically, Rice seeks to improve Wallis patients’ satisfaction with
their access to care, appointments, and information during the Waiver by a percentage that will be determined in DY3.
Project Option 1.1.1: Establish more primary care clinics- Expand primary care clinics

**Unique Project ID:** 212060201.1.3  
**Performing Provider Name/TPI:** Rice Medical Center / 212060201

**Project Description:**  
*Rice Medical Center proposes to expand primary care access in the greater Colorado County area by establishing a clinic in Wallis, Texas.*

In an effort to improve access to primary care in the greater Colorado County area, Rice will establish a primary care clinic in Wallis, Texas. This clinic will be operated by a mid-level provider supervised by a physician. Rice believes that this clinic will allow patients in the Wallis area to receive care appropriate to the medical conditions they experience.

**Goals and Relationship to Regional Goals:**

The goal of this project is to improve access to specialty care in the greater Colorado County area, and in particular the Wallis area.

**Project Goals:**

- Increase the availability of primary care services for patient populations in the Wallis area.
- Provide an estimated 750 encounters in DY3 (“baseline”), with a 33% increase over baseline in DY4, and a 100% increase over baseline in DY5.

This project meets the following regional goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

This project will improve patient outcomes and patient satisfaction by allowing patients to receive better and more effective primary care than that which is currently available to them.

Furthermore, this project will increase primary care services for the underserved population of the Wallis, Texas area.

**Challenges:**

Expected challenges include: (1) recruiting staff for the clinic; and (2) negotiating space for the clinic location. Rice will confront these challenges by offering competitive reimbursement for
the provider(s) assigned to provide care in Wallis and by locating community space available for Rice to use for the clinic until it can locate a permanent location.

5-Year Expected Outcome for Provider and Patients:

Rice expects this project to result in improved patient health outcomes due to easier access to primary care that is geographically proximate to the patients who need this care. Rice expects patient satisfaction to increase as a result of increased access to primary care and the attendant better outcomes.

Starting Point/Baseline:

The residents of Wallis, Texas do not have any access to local primary care services and must travel outside of their local community in order to obtain such services. The population of Wallis according to the 2010 census was 1252 people, and the population of Austin County in 2011 was 28,665 people. Rice estimates that the catchment area of the clinic will include at least 2500 people. The uninsured rate in Austin County is 24%, thus the target population includes at least 600 unique patients.

Rationale:

The residents of Wallis have no local primary care services. The clinic will serve this population and receive a patient flow from within a ten-mile radius. Wallis is located in Austin County (neighbor to Colorado County, where Rice Medical Center is located), and its ratio of patients to primary care physicians is over 4 times that of the statewide average (4505:1 and 1050:1, respectively). The population of Austin County, including Wallis, suffers from a higher rate of poor physical and mental health days and preventable hospitals stays than the statewide average. There is logically a connection between the paucity of primary care providers in Austin County and the high incidence of poor health in the community. Rice believes that opening a local clinic will go far towards improving the health of the Wallis community.

Project Components:

This project will address the core requirements of this project option in the following ways:

3. Rice will establish a new primary care clinic in Wallis, Texas.

Unique community need identification numbers the project addresses:

- CN-1: Inadequate access to primary care
  - Consequences include: patients’ inability to locate a medical home; delayed diagnoses and treatment which leads to more serious health care conditions and higher costs; inappropriate utilization of emergency room facilities and higher costs; lack of care coordination and patient education. Community needs include: increased access through more clinics/providers/facilities; expansion of clinic hours and appointment times; improved transportation options for patients who have problems getting to a provider; expansion of provider training and
recruitment programs; improved care coordination and patient education to ensure patients receive the right care at the right time.

- CN-8: High rates of inappropriate emergency department utilization

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

This project is a significant new initiative because it will result in the provision of primary care services that are currently unavailable in the Wallis community.

**Related Category 3 Outcome Measures:**

OD-6: Patient Satisfaction; IT 6.1(5): Percent improvement over baseline of patient satisfaction—patient’s overall health status; 212060201.3.6

**Reasons/rationale for selecting the outcome measures:**

This outcome measure ties in directly with the goal of this project, which is to increase the overall health of residents of the Wallis community by making primary care services available in their community.

**Relationship to other Projects:** This project relates to the following projects that Rice is submitting in RHP Region 3: Increase Access to Specialty Care, Chronic disease management.

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

**Project Valuation:** The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. The value of this project derives from the investment necessary to implement the new clinic, its expected impact on the community (in particular, increased and easier access to essential primary care for Wallis residents), and its expected impact on the institutional cost of providing care (earlier intervention through primary care services should lead to better outcomes and lower costs). It is generally understood in the medical community that regular access to and use of primary care services improves patient overall health outcomes, disease management, and quality of life. Rural patients are especially likely to have difficulty accessing primary care in their communities, thus this project meets a critical community need in the Wallis community.
<table>
<thead>
<tr>
<th>Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent Improvement over Baseline of Patient Satisfaction Scores</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 1 [P-X]:** Submit a plan, in order to do appropriate planning for the implementation of major infrastructure development.

**Metric 1 [P-X.1]:** Create a plan for establishing the Wallis Clinic, which includes identifying space, necessary equipment, staff, and a strategy for community outreach.

Data source: documentation of the plan

Milestone 1 Estimated Incentive Payment: $657,164

Milestone 2 [P-1]: Establish additional/expand existing/relocate primary care clinics

**Metric 1 [P-1.1]:** Number of additional clinics or expanded hours or space.

Baseline/Goal: Rice intends to establish a new clinic in Wallis, Texas. During DY3, Rice estimates that the new clinic will provide 750 patient encounters.

Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider.

Milestone 2 Estimated Incentive Payment: $579,851

Milestone 3 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 [I-12.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period.

Baseline/Goal: Rice will target a 33% increase in the total number of patient encounters over the DY3 baseline (estimated to be a total of 1000 encounters).

Data Source: Registry; EHR; claims; other Performing Provider source.

Milestone 3 Estimated Incentive Payment: $541,194

Milestone 4 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 [I-12.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period.

Baseline/Goal: Rice will target a 100% increase in the total number of patient encounters over the DY3 baseline (estimated to be a total of 1500 encounters).

Data Source: Registry; EHR; claims; other Performing Provider source.

Milestone 4 Estimated Incentive Payment: $407,030

**Total Estimated Incentive Payments for 4-Year Period:** $2,100,239

Year 2 Estimated Milestone Bundle Amount: $657,164

Year 3 Estimated Milestone Bundle Amount: $579,851

Year 4 Estimated Milestone Bundle Amount: $541,194

Year 5 Estimated Milestone Bundle Amount: $407,030
Project Option 1.6.1 – Expand urgent care services- Enhance urgent medical advice.

Unique RHP Project Identification Number: 212060201.1.4
Performing Provider Name/TPI: Rice TPI/212060201

- **Provider:** Rice Medical Center is a critical access hospital located in Eagle Lake, Colorado County, TX. The county population served by Rice is approximately 21,000. Rice also serves the town of East Bernard in Wharton County with a population of approximately 2,000.

- **Intervention(s):** In an effort to enhance the urgent medical advice resources available to patient populations in Colorado County, Rice Medical Center will establish a new urgent care clinic. This new clinic will be an outpatient clinic and will be physically located in Rice’s hospital facility. Non-emergent patients who present at Rice’s Emergency Department will be directed to this new urgent care clinic and given the option of seeking urgent care at the clinic instead of emergent care at the Emergency Department, making it easier for patients to make a real and informed choice to utilize the most appropriate level of care for their particular medical conditions and reducing the costs of non-emergent care.

- **Need for the project:** Rice has experienced an overutilization of its Emergency Department, due to patients not seeking and/or having access to the appropriate level of care. The urgent care clinic to be implemented by this project will provide a convenient alternative for these patients, redirecting them from Rice’s Emergency Department and reducing the costs associated with treating them, while also improving the quality of their care.

- **Target population:** The target population of this project is non-emergent patients who are currently using Rice’s Emergency Department even though it is not the appropriate level of care given their particular conditions. Approximately 68% of Rice’s ED encounters are non-emergent cases (1953/2863 in 2012), and approximately 71% of the non-emergent visits were Medicaid-eligible or uninsured in 2012.

- **Category 1 or 2 expected patient benefits:** The goal of this project is to enhance urgent medical advice in Colorado County. Specifically, in DYs 2-3 Rice will establish a baseline of ED encounters and train nurses in protocols for redirecting patients; in DY3, Rice estimates that it will redirect 700 ED encounters to the Urgent Care Clinic; in DY 4 Rice will increase the volume of patients electing to receive treatment in the new clinic by 42% over DY3’s volume (expected to mean 1000 encounters in the Urgent Care); and in DY5, Rice will increase the volume of patients electing to receive treatment in the new clinic by 100% over DY3’s volume (expected to mean 1400 encounters in the Urgent Care).

- **Category 3 outcomes:** IT 2.7 - Rice chose this outcome measure because it ties in directly with the goal of this project, which is to provide patients with the opportunity to choose the most appropriate level of care for their urgent conditions, rather than seeking treatment for non-emergent conditions at Rice’s Emergency Department and ultimately being admitted as inpatients. Rice is targeting an impact on PPAs for short
term diabetes complications because diabetes is prevalent in the community and can lead to costly consequences down the line.
Project Option 1.6.1 – Expand urgent care services- Enhance urgent medical advice.

**Unique Project ID:** 212060201.1.4  
**Performing Provider Name/TPI:** Rice Medical Center / 212060201

**Project Description:**  
*Rice Medical Center proposes to enhance urgent medical advice in Colorado County by establishing an outpatient urgent care clinic in its hospital facility.*

In an effort to enhance the urgent medical advice resources available to patient populations in Colorado County, Rice Medical Center will establish a new urgent care clinic. This new clinic will be an outpatient clinic and will be physically located in Rice’s hospital facility. Non-emergent patients who present at Rice’s Emergency Department will be directed to this new urgent care clinic and given the option of seeking urgent care at the clinic instead of emergent care at the Emergency Department, making it more possible for patients to make a real and informed choice to utilize the most appropriate level of care for their particular medical conditions and reducing the costs of non-emergent care. More than 60% of the patients who utilize Emergency Department services at Rice’s hospital facility are Medicaid or uninsured.

**Goals and Relationship to Regional Goals:**

The goal of this project is to enhance urgent medical advice in Colorado County.

**Project Goals:**

- Establish an urgent care center in the Rice hospital facility.
- Direct non-emergent patients presenting at the Emergency Department to the urgent care center when appropriate, allowing such patients to voluntarily choose the most appropriate level of care.
- Ultimately redirect approximately 1000 patient visits to the Urgent Care Center in DY4, and approximately 1400 patient visits to the Urgent Care Centers in DY5.

This project meets the following regional goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
This project will leverage existing infrastructure in that the new urgent care services will be provided in Rice’s existing hospital facility; it will also improve patient outcomes and patient satisfaction.

Furthermore, this project will increase urgent care services for an underserved population, regardless of where they live, allowing residents of Colorado County to receive the care most appropriate to their particular medical conditions.

**Challenges:**

Expected challenges include: (1) staffing the urgent care clinic; (2) informing patients of the availability of urgent care services at the urgent care clinic.

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

Rice expects this project to result in improved patient health outcomes due to easier access to the most appropriate level of care for each patient’s condition. Rice also expects a reduction in improper Emergency Department utilization.

**Starting Point/Baseline:**

There is currently no urgent care clinic in Rice’s hospital facility. Urgent patients have few alternatives other than presenting at Rice’s Emergency Department and seeking emergent care. In 2012, Rice experienced 2863 ED visits, 1953 of which were deemed non-emergent (68%). Of those non-emergent visits, 1390 were from Medicaid-eligible or uninsured patients (71%). Clearly there is a need to redirect patients into the right care setting, which Rice expects to result in improved health outcomes for patients and reduced systemic costs of treating indigent patients.

**Rationale:**

When patients receive the level of care most appropriate to their particular conditions, better patient outcomes will result. Additionally, Rice has experienced an overutilization of its Emergency Department, due to patients not seeking the appropriate level of care. The urgent care clinic to be implemented by this project will provide a convenient alternative for these patients, redirecting them from Rice’s Emergency Department and reducing the costs associated with treating them, while also improving the quality of their care.

**Project Components:**

This project will address the core requirements of this project option in the following ways:

4. Rice will establish an outpatient urgent care clinic in its hospital facility.
5. Once this clinic is established, Rice will refine the operations of the clinic by conducting quality improvement for the project using methods such as rapid cycle improvement.

Unique community need identification numbers the project addresses:

- CN-1: Insufficient access to primary and specialty health care providers and facilities (increase number of providers, expansion of clinic hours, service locations). Consequences include: patients’ inability to locate a medical home; delayed diagnoses and treatment which leads to more serious health care conditions and higher costs; inappropriate utilization of emergency room facilities and higher costs; lack of care coordination and patient education. Community needs include: increased access through more clinics/providers/facilities; expansion of clinic hours and appointment times; improved transportation options for patients who have problems getting to a provider; expansion of provider training and recruitment programs; improved care coordination and patient education to ensure patients receive the right care at the right time.
- CN-8: High rates of inappropriate emergency department utilization

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

This project is a significant new initiative because it will result in the provision of urgent care services that are currently unavailable in Colorado County.

Related Category 3 Outcome Measures:

OD-2: Potentially Preventable Admissions  IT-2.7: Diabetes Related Short-Term Complications 212060201.3.7

Reasons/rationale for selecting the outcome measures:

This outcome measure ties in directly with the goal of this project, which is to provide patients (including those with diabetes) with the opportunity to choose the most appropriate level of care for their urgent conditions, rather than seeking treatment for non-emergent conditions at Rice’s Emergency Department and ultimately becoming inpatients in the hospital facility.

Relationship to other Projects: This project relates to the following projects that Rice is submitting in RHP Region 3: Chronic disease management; Expand Primary Care Access (East Bernard and Wallis clinics).

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

**Project Valuation:** The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. The value of this project derives from the investment necessary to implement the hospital-based urgent care clinic, its expected impact on the community (in particular, increased and easier access to urgent care for Colorado County residents), and its expected impact on the institutional cost of providing care (i.e., a reduction of inappropriate Emergency Department utilization by directing patients to more appropriate and less costly sites of care). This project represents an innovative solution to problems faced in the community – ideally, patients will access primary care outside of the hospital setting, but until bad habits are changed, patients can access urgent care services onsite at the hospital instead of being admitted to the ED. This project will have a broad impact on the community, including on the 1 in 5 patients Rice treats who are completely uninsured, and for that reason it is a valuable project.
### Potentially Preventable Admissions

<table>
<thead>
<tr>
<th>Year</th>
<th>Outcome Measure(s)</th>
<th>Rice Medical Center</th>
<th>ENHANCE URGENT MEDICAL ADVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>212060201.3.7</td>
<td>Related Category 3</td>
<td>212060201.1.4</td>
</tr>
<tr>
<td>Year 3</td>
<td>IT 2.7</td>
<td>Outcome Measure(s):</td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td>Year 5</td>
<td>Milestone 1 [P-X]: Establish baseline for metrics P-3.1 and I-17.1.</td>
<td>Milestone 2 [P-3]: Train nurses on clinical protocols.</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Milestone 2 [P-3]: Train nurses on clinical protocols.</td>
<td>Milestone 3 [I-17]: Implement interventions to improve access to care of patients receiving urgent medical advice.</td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td>Metric 1 [P-X1.1]: Establish a baseline of the number of patients presenting at the Rice Medical Center ED who are deemed non-emergent. Also collect data about how many of those patients are uninsured/indigent, and how many of those patients have access to affordable urgent and/or primary care in the community.</td>
<td>Metric 1 [I-17.1]: Documentation of increased number of unique patients served by innovative program.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Metric 1 [P-3.1]: Number of nurses trained to treat patients in Rice’s new urgent care clinic. Baseline/Goal: Train/hire at least 2 nurses capable of staffing the urgent care clinic. Data Source: Documentation of new/expanded specialty care clinic staffing.</td>
<td>Baseline/Goal: Rice anticipates redirecting 700 patient visits from the ED to the Urgent Care Clinic in FY3. In FY4, Rice is targeting a 42% increase in volume of patients seen in the Urgent Care over FY3, estimated to result in 1000 visits. Data Source: Registry; EHR; claims; other Performing Provider source.</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $610,224</td>
<td>Milestone 2 Estimated Incentive Payment: $574,328</td>
<td>Milestone 3 Estimated Incentive Payment: $538,433</td>
<td>Milestone 4 Estimated Incentive Payment: $409,209</td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $610,224</td>
<td>Year 3 Estimated Milestone Bundle Amount: $574,328</td>
<td>Year 4 Estimated Milestone Bundle Amount: $538,433</td>
<td>Year 5 Estimated Milestone Bundle Amount: $409,209</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $2,132,194
Project Option 1.9.2: Improve access to specialty care - Improve access to specialty care in Colorado County

Unique RHP Project Identification Number: 212060201.1.5
Performing Provider Name/TPI: Rice TPI/212060201

- **Provider:** Rice Medical Center is a critical access hospital located in Eagle Lake, Colorado County, TX. The county population served by Rice is approximately 21,000. Rice also serves the town of East Bernard in Wharton County with a population of approximately 2,000.

- **Intervention(s):** In an effort to improve access to specialty care in Colorado County, Rice will recruit an otolaryngologist (ENT physician) to provide patient testing, treatment, and, when necessary, referrals to appropriate facilities within RHP Region 3. Rice intends for this ENT physician to provide an additional 4 hours per week of clinic hours. Rice will also improve access to specialty care in Colorado County by recruiting a qualified orthopedic provider to provide patient testing, treatment, and, when necessary, referrals to appropriate facilities within RHP Region 3. Rice also intends for this orthopedic provider to provide an additional 4 hours per week of clinic hours.

- **Need for the project:** ENT and orthopedic specialty healthcare services are currently unavailable in the Rice Hospital District service area. The rural nature of this area makes it very difficult for patients to obtain the specialty care they need, often requiring them to travel hundreds of miles to see specialist providers. According to the Region’s County Health Rankings, Colorado County has a higher rate of premature death, poor physical health days, and adult obesity than the statewide average. Obesity can cause or be related to conditions appropriate for ENT or orthopedic care (i.e. snoring/sinus conditions, joint deterioration, etc.), indicating a need for these specialties in this community where obesity is especially prevalent. This is especially important because both of these specialists are trained in medicine and surgery, which most PCPs are not.

- **Target population:** The target population of this project is patients in Colorado County who have needs for ENT and orthopedic specialty healthcare services but currently do not have access. Rice’s Eagle Lake Clinic, located near where the specialists will provide care, provided 11,800 encounters to 4200 unique patients in 2012, and 45% of those patients were Medicaid-eligible or uninsured (approximately 1900 patients). Rice’s hospital facility, which is where the specialty clinic will be located, treated approximately 3650 patients in 2012, 50% of whom were Medicaid-eligible or uninsured. Any of those patients with hearing loss (estimated to be 1/10 Americans), allergies, sinitus, and chronic joint conditions are expected to benefit from access to local referrals to see these specialists.

- **Category 1 or 2 expected patient benefits:** Rice expects this project to result in improved patient health outcomes due to easier access to these specialists for the purposes of diagnosis, treatment and referrals. Specifically, Rice will recruit the specialists and launch the specialty clinic in DYs 2-3 (providing an estimated, combined 700 visits in DY3), and will improve the patient volume treated by the specialists by 28.5% over DY3
in DY4 (providing an estimated 900 visits), and by another 33% in DY5 over DY4 (providing an estimated 1200 visits).

- **Category 3 outcomes:** IT 6.1 - Rice chose the patient satisfaction outcome measure because it ties in directly with the goal of this project, which is to allow patients and their primary care physicians to have access to specialists for consultations and referrals.
Project Option 1.9.2: Improve access to specialty care - Improve access to specialty care in Colorado County

**Unique Project ID:** 212060201.1.5
**Performing Provider Name/TPI:** Rice Medical Center / 212060201

**Project Description:**
*Rice Medical Center proposes to improve access to specialty care in Colorado County*

In an effort to improve access to specialty care in Colorado County, Rice will recruit an otolaryngologist (ENT physician) to provide services at least once a week in its specialty clinic. This clinic is located next to the hospital (Eagle Lake Clinic), making it particularly accessible to the Colorado County community and the patient population which the project is intended to serve. This ENT physician will provide patient testing, treatment, and, when necessary, referrals to appropriate facilities within RHP Region 3. Rice intends for this ENT physician to provide an additional 4 hours per week of clinic hours at Rice’s clinic.

Rice will also improve access to specialty care in Colorado County by recruiting a qualified orthopedic provider to provide services at least once a week in its specialty clinic located next to the hospital. This orthopedic provider will provide patient testing, treatment, and, when necessary, referrals to appropriate facilities within RHP Region 3. Rice intends for this orthopedic provider to provide an additional 4 hours per week of clinic hours at Rice’s clinic.

**Goals and Relationship to Regional Goals:**

The goal of this project is to improve access to specialty care in Colorado County, for those services most needed by Rice’s patient population. Providing local access to specialty care at Rice’s clinic will decrease delayed referrals to Houston hospitals for costly and potentially preventable services.

**Project Goals:**

- Recruit an ENT and orthopedic provider to provide services in Rice’s Eagle Lake Clinic
- Increase the volume of patient testing, treatment, and referrals in the community by recruiting an ENT physician.
- Increase the volume of patient testing, treatment, and referrals in the community by recruiting an orthopedic provider.

This project meets the following regional goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
• Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

This project will leverage existing infrastructure in that the new specialty care services will be provided in an existing clinic located in Rice’s existing hospital facility; it will also improve patient outcomes and patient satisfaction.

Furthermore, this project will increase specialty care services for an underserved population, regardless of where they live.

Challenges:

Expected challenges include: (1) locating and recruiting the appropriate candidates willing and able to provide specialty care to an underserved community; and (2) patient education about the increased availability of services.

5-Year Expected Outcome for Provider and Patients:

Rice expects this project to result in improved patient health outcomes due to easier access to these specialists for the purposes of diagnosis, treatment and referrals. Rice also expects a reduction in the cost of obtaining this care for patients; one particular area in which these costs will be reduced is travel costs, as orthopedic and ENT patients will no longer need to travel to larger healthcare markets in order to obtain their needed care.

Starting Point/Baseline:

Patients in the Colorado County community currently have limited access to orthopedic specialists or ENT specialists in their community. The easiest way for these patients to obtain the care they need is to travel to Houston, but many are unable to do so. The Eagle Lake Clinic, which is close to where the specialists will provide services, served approximately 4200 unique patients with approximately 11,800 encounters in 2012, and 45% of those patients were Medicaid eligible/uninsured. Rice’s hospital facility, wherein the specialists will provide clinic services, treated approximately 3650 patients in 2012, 50% of whom were Medicaid eligible/uninsured. Any of those patients with ENT or orthopedic needs will be targeted for referrals under this project.

Rationale:

ENT and orthopedic specialty healthcare services are currently unavailable in the Rice Hospital District service area. The rural nature of this area (and of Colorado County in general) makes it very difficult for patients to obtain the specialty care they need, often requiring them to travel hundreds of miles to see specialist providers. According to the Region’s County Health Rankings, Colorado County has a higher rate of premature death, poor physical health days, low birth weight, and adult obesity than the statewide average. Each of these statistics can be tied
to conditions requiring specialty care that may not be available in Colorado County, supporting Rice’s initiative to increase access to needed care and decrease the burden on patients through expanding specialty services at its in-hospital specialty clinic.

**Project Components:**

This project will address the core requirements of this project option in the following ways:

6. Rice will increase specialty service availability by extending clinic hours for orthopedic and ENT specialty services. Rice intends that each provider will provide these additional services for an additional 4 hours per week at the hospital’s specialty clinic.

7. Rice will increase the number of specialty clinic locations in Colorado County providing ENT and orthopedic services by recruiting these providers. Currently there are no clinics in Colorado County providing ENT or orthopedic specialty services.

8. Rice will increase specialty service availability by implementing standardized specialty referrals throughout its system; these particular referrals will be made by the ENT and orthopedic specialty providers who will provide services under this project.

9. Rice will continue to develop this project by conducting quality improvement for the project using methods such as rapid cycle improvement.

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

- **CN-1:** Insufficient access to primary care
- **CN-2:** Insufficient access to specialty health care
  - Consequences include: patients’ inability to locate a medical home; delayed diagnoses and treatment which leads to more serious health care conditions and higher costs; inappropriate utilization of emergency room facilities and higher costs; lack of care coordination and patient education. Community needs include: increased access through more clinics/providers/facilities; expansion of clinic hours and appointment times; improved transportation options for patients who have problems getting to a provider; expansion of provider training and recruitment programs; improved care coordination and patient education to ensure patients receive the right care at the right time.

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

This project is a significant new initiative because it will result in the provision of specialty services that are currently unavailable in Colorado County.
**Related Category 3 Outcome Measures:**

OD-6: Patient Satisfaction; IT 6.1(3): Percent improvement over baseline of patient satisfaction—patient’s rating of doctor access to specialist; 212060201.3.8

**Reasons/rationale for selecting the outcome measures:**

This outcome measure ties in directly with the goal of this project, which is to allow patients and their primary care physicians to have access to specialists for consultations and referrals.

**Relationship to other Projects:** This project relates to the following projects that Rice is submitting in RHP Region 3: Increase access to primary care (East Bernard and Wallis).

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

**Project Valuation:** The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. The value of this project derives from the investment necessary to implement it (recruiting and retaining qualified physicians willing to work in a rural county, training and integrating the new physicians), its expected impact on the community (in particular, increased and easier access to specialists for Colorado County residents), and its expected impact on the institutional cost of providing care (earlier intervention by an appropriate specialist should lead to better outcomes and lower costs for patients with relevant ailments). Regional transformation of the healthcare delivery system must include increasing the access to the full continuum of care for rural residents, and especially for those residents who have financial or mobility difficulties. This project will address this goal of the Waiver head-on.
### IMPROVE ACCESS TO SPECIALTY CARE IN COLORADO COUNTY

**Rice Medical Center**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>212060201.3.8</th>
<th>IT-6.1</th>
<th>Percent Improvement over Baseline of Patient Satisfaction Scores</th>
</tr>
</thead>
</table>

#### Year 2
(10/1/2012 – 9/30/2013)

**Milestone 1** [P-X]: Establish baseline for metrics P-11.1, I-23.3

**Metric 1** [P-X1.1]: Establish baseline of the number of referrals from Rice hospital and clinic providers to unassociated specialists (ENT and orthopedic) outside of the community, in order to project and measure impact of project in future years.

Data source: clinic/hospital patient data

**Milestone 1 Estimated Incentive Payment:** $751,045

<table>
<thead>
<tr>
<th>Year 3</th>
<th>(10/1/2013 – 9/30/2014)</th>
</tr>
</thead>
</table>

**Milestone 2** [P-11]: Launch/expand a specialty care clinic

**Metric 1** [P-11.1]: Establish/expand specialty care clinics.

Baseline/Goal: 8 additional hours of clinic services per week for ENT/orthopedic specialty care.

Data Source: Documentation of new/expanded specialty care clinic.

**Milestone 2 Estimated Incentive Payment:** $662,687

#### Year 4
(10/1/2014 – 9/30/2015)

**Milestone 3** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1** [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.

Baseline/Goal: Rice expects to provide 700 patient encounters through the ENT/orthopedic specialists providing care through the new clinic. In DY4, the specialists will increase the volume of visits by 28.5% over DY3’s volume (estimated 900 encounters)

Data Source: Registry; EHR; claims; other Performing Provider source.

**Milestone 3 Estimated Incentive Payment:** $618,507

#### Year 5
(10/1/2015 – 9/30/2016)

**Milestone 4** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1** [I-23.3]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.

Baseline/Goal: Rice expects to provide 700 patient encounters through the ENT/orthopedic specialists providing care through the new clinic. In DY5, the specialists will increase the volume of visits by 33% over DY4’s volume (estimated 1200 encounters)

Data Source: Registry; EHR; claims; other Performing Provider source.

**Milestone 4 Estimated Incentive Payment:** $459,463

**Year 2 Estimated Milestone Bundle Amount:** $751,045

**Year 3 Estimated Milestone Bundle Amount:** $662,687

**Year 4 Estimated Milestone Bundle Amount:** $618,507

**Year 5 Estimated Milestone Bundle Amount:** $459,463

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $2,491,701
Project Option 1.1.2: Expand existing primary care capacity - Expand the East Bernard Clinic

Unique RHP Project Identification Number: 212060201.1.6
Performing Provider Name/TPI: Rice TPI/212060201

- **Provider**: Rice Medical Center is a critical access hospital located in Eagle Lake, Colorado County, TX. The county population served by Rice is approximately 21,000. Rice also serves the town of East Bernard in Wharton County with a population of approximately 2,000.

- **Intervention(s)**: Rice intends to relocate and improve the existing Rural Health Clinic ("RHC") in East Bernard in order to expand access to primary care services in this community and a surrounding radius of at least 10 miles outside the city limits. Additionally, the new clinic will have updated equipment and will be a more welcoming environment for patients than the existing clinic space, which is quite old and outdated. Rice will provide more clinic hours through the expanded East Bernard Clinic than the current RHC provides so that working residents and the school-age children of East Bernard and the surrounding community have access to this primary care source. Rice will also expand the East Bernard Clinic staffing from its current level by at least one provider (physician or mid-level) by the end of the Waiver (DY5), in addition to the FP/OB added to the clinic as part of a separate project.

- **Need for the project**: Like the rest of Wharton County, East Bernard suffers from a higher rate of poor physical and mental health days and preventable hospital stays than the Statewide average; access to primary care may reduce these local trends, through improving the health of the community.

- **Target population**: The target population of this project is children, adults and seniors in need of primary care services. In particular, the members of this population who do not receive regular services but instead wait until the situation is acute and requires hospitalization. The project will specifically target the 28% of Wharton County residents who are uninsured (approximately 11,500 people) and the 27% of children who live in poverty. In 2012, the East Bernard Clinic provided approximately 6845 encounters to approximately 2800 patients, and 23% of those patients were Medicaid or uninsured (650 patients).

- **Category 1 or 2 expected patient benefits**: The goal of this project is to establish a primary care clinic that will increase the availability of preventative care, including child, adult, geriatric and women's health services. Rice expects an increase in the clinic volume of visits by 685 visits in DY4 (10% increase), and by 1027 visits in DY5 (15% increase), over the DY2 baseline (estimated to be 6845 visits).

- **Category 3 outcomes**: IT 6.1 - Rice chose the patient satisfaction outcome because one of the goals of expanding the East Bernard Clinic is to improve patients’ access to primary care services. Thus, it is important that patients perceive that they can access appointments and information; if they do not, then Rice will need to adjust its outreach.
to the community to assure that residents are aware of the services available to them and/or make internal changes to increase access.
Project Option 1.1.2: Expand existing primary care capacity- Expand the East Bernard Clinic

**Unique RHP Project ID:** 212060201.1.6  
**Performing Provider Name/TPI:** Rice Medical Center / 212060201

**Project Description:**

The East Bernard community lacks adequate primary care services and, as a result, its population relies on hospital services rather than preventive care. Complicating the situation is the fact that residents do not receive regular services so they wait until the situation is acute and requires hospitalization. As such, Rice intends to relocate and improve the existing Rural Health Clinic (“RHC”) in East Bernard in order to expand access to primary care services in this community and a surrounding radius of at least 10 miles outside the city limits.

**Goals and Relationship to Regional Goals:**

Rice’s specific goals for this project include:

1) Move the existing East Bernard clinic into a space with more than double the amount of square footage in DY2  
2) Expand the hours of appointment availability at the clinic by 9 hours per week, which will include at least 3 hours of availability after work hours or on weekends, in DY3  
3) Hire/contract with at least one additional physician/mid-level provider to furnish primary care services at the clinic in DY3 (separate from the FP/OB providing services in the clinic as part of a separate project  
4) Increase the clinic volume of visits by 685 visits in DY4, and by 1027 visits in DY5, over the DY2 baseline (estimated to be 6845 visits).

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

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

Expected challenges include: (1) recruiting staff for the clinic, (2) coordinating the hours of the clinic so that patients use the clinic in lieu of emergency departments for low acuity services, and (3) locating, designing, equipping, and opening the new space.

5-Year Expected Outcome:

The goal of this project is to establish a primary care clinic that will increase the availability of preventative care, including child, adult, geriatric and women's health services. Rice expects that this expansion will result in increased patient volume for the East Bernard Clinic by at least 15% over the life of the Waiver.

Starting Point/Baseline:

Currently, the East Bernard RHC has 1.5 practitioners on staff, is open 35 hours per week, and has 2247 square feet of space. In 2012 the clinic treated 2778 unique patients and provided 6,845 encounters. Of the 2778 unique patients, 649 were Medicaid/uninsured (23%).

Rationale:

Like the rest of Wharton County, East Bernard suffers from a higher rate of poor physical and mental health days and preventable hospital stays than the Statewide average; access to primary care may reduce these local trends, through improving the health of the community. Additionally, 28% of Wharton County residents are uninsured and 27% of children live in poverty, thus it is crucial to improving patient health outcomes and the cost of providing care that these residents have access to primary care in the community without having to visit the hospital ED.

Project Components:

Rice will meet the core requirements of this project in the following manner:

1. Rice is expanding the primary care clinic space in East Bernard. The new clinic facility will have more square footage than the existing clinic, which only occupies 2247 square feet. The new clinic will occupy 5810 square feet. Additionally, the new clinic will have updated equipment and will be a more welcoming environment for patients than the existing clinic space, which is quite old and outdated.

2. Rice will provide more clinic hours through the expanded East Bernard Clinic than the current RHC provides (which is approximately 35 hours per week). Specifically, the clinic will provide service availability at least 9 more hours per week than it currently provides. Additionally, the clinic’s hours will be structured to allow for some availability after hours and/or on weekends, so that working residents and the school-age children of East Bernard and the surrounding community have access to this primary care source.
3. Rice will expand the East Bernard Clinic staffing from its current level by at least one provider (physician or mid-level) by the end of the Waiver (DY5). This will be in addition to the FP/OB that will be added to the clinic as part of a separate project to expand access to care for women in Wharton County.

**Ties to unique Region community needs:**

CN.1- Inadequate access to primary care  
CN.3- Inadequate access to behavioral health care  
CN.10- High rates of preventable hospital admissions  
CN.12- High rates of tobacco use and excessive alcohol use  
CN.13- High teen birth rates  
CN.14- High rates of poor birth outcomes and low birth-weight babies  

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

The East Bernard clinic is currently in operation, but the relocation to a larger space with increased capacity is a new initiative for Rice.

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

OD-6 Patient Satisfaction, IT 6.1 Percent improvement over baseline of patient satisfaction scores: (1) patients are getting timely care, appointments, and information

**Reasons/Rationale for selecting the outcome measure:**

Rice chose this Outcome because one of the goals of expanding the East Bernard Clinic is to improve patients’ access to primary care services. Thus, it is important that patients perceive that they can access appointments and information; if they do not, then Rice will need to adjust its outreach to the community to assure that residents are aware of the services available to them and/or make internal changes to increase access.

**Relationship to other Projects:** This project is related to Rice’s project to add an FP/OB to the East Bernard Clinic, in that each is intended to improve access to primary care in the community; however, this project will increase patient encounters above and beyond the additional appointments and hours provided by the FP/OB. **Relationship to Other Performing Providers’ Projects in the RHP:**

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

**Project Valuation:** The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Access to primary care is essential to improving the short- and long-term health outcomes for East Bernard’s residents, and for reducing the cost of health care delivery in the County. Primary and preventative care can lead to reduced rates of chronic disease, better management of chronic conditions, and improved patient education about best-practices for maintaining a healthy lifestyle, which is invaluable to for the overall health of the community. Patients in rural areas like Wharton County already have difficulty accessing primary care (due to a shortage of providers), and the high uninsured rate in the community exacerbates this problem significantly. Patients without access to primary care are more likely to use the ED for primary care needs, which is a behavior this project seeks to address. Thus, this project is high value for Rice. The project will require significant investment in recruiting, identifying, obtaining, and equipping the increased space, and working with providers to increase the hours of availability and the volume of patients treated per week.
<table>
<thead>
<tr>
<th><strong>Milestone 1 [P-1]:</strong> Establish additional/expand existing/relocate primary care clinics.</th>
<th><strong>Milestone 2 [P-5]:</strong> Train/hire additional primary care providers and staff.</th>
<th><strong>Milestone 4 [I-12]:</strong> Increase primary care clinic volume of visits and evidence of improved access for patient seeking services.</th>
<th><strong>Milestone 5 [I-12]:</strong> Increase primary care clinic volume of visits and evidence of improved access for patient seeking services.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1 [P-1.1]:</strong> Number of additional clinics or expanded hours or space&lt;br&gt;Goal: Rice will relocate the existing RHC in East Bernard to a larger, newer space in order to serve additional patients and improve the patient experience.&lt;br&gt;Amount of expanded space – estimated to be an additional 3500 square feet.&lt;br&gt;Data source: Documentation of detailed expansion plans</td>
<td><strong>Metric 1 [P-5.1]:</strong> Documentation of increased number of providers and staff and/or clinic sites.&lt;br&gt;Goal: Documentation of increased number of providers. - Rice will hire/contract with at least one additional physician and/or mid-level to provide services at the East Bernard Clinic.&lt;br&gt;Data source: Provider contract or schedule evidencing employment at the clinic</td>
<td><strong>Metric 1 [I-12.1]:</strong> Documentation of increased number of visits.&lt;br&gt;Goal: Rice will increase the East Bernard Clinic’s volume of patients by 10% over its DY2 baseline volume. Because Rice provided approximately 6,845 visits in 2012, Rice anticipates the 10% increase will represent 685 additional encounters to an estimated 275 additional patients.&lt;br&gt;Data source: Electronic Health Records/Registry maintained by the clinic</td>
<td><strong>Metric 1 [I-12.1]:</strong> Documentation of increased number of visits.&lt;br&gt;Goal: Rice will increase the East Bernard Clinic’s volume of patients by 15% over its DY2 baseline volume. Because Rice provided approximately 6,845 visits in 2012, Rice anticipates the 15% increase will represent 1027 additional encounters to an estimated 410 additional patients.&lt;br&gt;Data source: Electronic Health Records/Registry maintained by the clinic</td>
</tr>
<tr>
<td><strong>Milestone 3 [P-4]:</strong> Expand the hours of a primary care clinic, including evening or weekend hours.</td>
<td><strong>Milestone 4 Estimated Incentive Payment:</strong> $289,925.50</td>
<td><strong>Milestone 4 Estimated Incentive Payment:</strong> $541,194</td>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $402,030</td>
</tr>
<tr>
<td><strong>Metric 1 [P-4.1]:</strong> Increased number of hours at primary care clinic over baseline&lt;br&gt;Goal: Increased number of hours at primary clinic over baseline- Rice will increase the service hours at the East Bernard Clinic from DY3 by 9 hours per week, which include at least 3</td>
<td><strong>Numerator:</strong> volume of patients seen at the East Bernard Clinic in DY4&lt;br&gt;<strong>Denominator:</strong> same measurement for DY2</td>
<td><strong>Numerator:</strong> volume of patients seen at the East Bernard Clinic in DY5&lt;br&gt;<strong>Denominator:</strong> same measurement for DY2</td>
<td><strong>Numerator:</strong> volume of patients seen at the East Bernard Clinic in DY5&lt;br&gt;<strong>Denominator:</strong> same measurement for DY2</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>212060201.3.9</td>
<td>IT-6.1</td>
<td>Percent improvement over baseline of patient satisfaction scores: (1) patients are getting timely care, appointments, and information</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td>hours after work or on weekends. Data source: Clinic records of open service hours. Milestone 3 Estimated Incentive Payment: $289,925.50</td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Year 2 Estimated Milestone Bundle Amount: $657,164
Year 3 Estimated Milestone Bundle Amount: $579,851
Year 4 Estimated Milestone Bundle Amount: $541,194
Year 5 Estimated Milestone Bundle Amount: $402,030

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $2,180,239**
Project Option 1.11.3 Implement technology-assisted services to support, coordinate, or deliver behavioral health services-Client Health Information Access Portal

**Unique RHP Project ID:** 096166602.1.1 / Pass 2  
**RHP Performing Provider / TPI:** Spindletop Center / 096166602

**Project Summary:**

**Provider:** Spindletop Center is a public entity community center that provides services for approximately 2900 adult, child, and adolescent behavioral health clients, 1070 substance abuse clients, 980 adult and child individuals with intellectual and developmental disabilities, and 800 children in the early childhood intervention program. With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties. Orange, Hardin, Chambers counties and parts of Jefferson count have been designated by the Health Resources and Services Administration (HRSA) as Health Professional Shortage Areas (HPSAs).

**Intervention:** Spindletop will develop a web-based portal where secure client-focused health information can be accessed and will train our mental health clients with only basic computer skills to use the portal. This will support the behavioral health services Spindletop currently delivers by encouraging compliance with medication regimens, making individual healthcare information available to clients, and fostering peer support. Wi-Fi enabled tablets will be purchased by Spindletop and made available for select clients to check out to access their health information.

**Need for project:** The strategic plan of the U.S. Department of Health and Human Services’ (HHS) Office of the National Coordinator for Health Information Technology (ONC) identified patients’ participation as a “critical, yet currently underutilized, component in improving health and the overall health care system” and that “the single biggest lever to individual empowerment [over their health care] is access to data.” Healthcare providers are providing systems for electronic distribution of client health information via email or websites, but clients of intensive Medicaid services often have little or no access to the electronic devices that help them find and use healthcare information being provided via the internet. By developing the web-based portal, training clients how to access the information, and making electronic notebooks available for client use, this project would help our clients take charge of their own health and use resources that may have been out of reach to them.

**Target:** This project program is targeted primarily to the 2900 adult, child, and adolescent behavioral health clients that Spindletop serves. 54% of these adults and 88% of the child and adolescent clients are on Medicaid, with most of the remainder being indigent. Therefore,

---

almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.

Expected benefits: The expected outcome of this program by the end of demonstration year 5 is to improve the health care of Spindletop mental health clients and decrease health care costs by improving client access to health care information through the development of the client portal, training 1400 outpatient clients to access the information, and making electronic notebooks available for client use.

For demonstration year 2, the process milestone is to hire a project manager, purchase initial hardware/software, and contract with professional vendors to install software and deploy hardware. In DY3, the improvement milestone will be to continue development of the portal, test equipment, create training materials, and develop portal content; approximately 50 clients will be trained to test the program in DY3.

In DY 4, the improvement milestone will be to train 600 additional Spindletop behavioral health outpatient consumers to access the client portal.

In DY 5, the improvement milestone will be a reduction in ED visits for the clients who have been trained to use the client portal in DY3-4; the baseline for the ED visits will be established in DY4. This improvement milestone was selected since the goal of the project is to improve the health of the clients and reduce healthcare costs. Spindletop will continue to train additional clients in DY5.

Category 3 outcomes:

The Category 3 outcome measure is IT-6.1 percent improvement over baseline of patient satisfaction scores, patients getting timely health information. The survey will be designed to produce comparable data on the patient's perspective on care that will allow objective and meaningful assessment of the program in meeting the needs of the clients.
Project Option 1.11.3 Implement technology-assisted services to support, coordinate, or deliver behavioral health services-Client Health Information Access Portal

**Unique RHP Project ID:** 096166602.1.1 / Pass 2  
**RHP Performing Provider / TPI:** Spindletop Center / 096166602

**Description:**

**Goal:** The goal of this project is to support client health care, health-related education, public health and health administration by using the internet for clients to obtain specialized health information and on-line discussion groups to provide peer-to-peer support.

Description: Spindletop will develop a web-based portal where client-focused health information can be securely housed and easily accessed by users with only basic computer skills. Outpatient clients will be trained on the use of the portal, and Spindletop will purchase electronic notebooks to be available for clients to use the program. The client web portal will be designed to provide immediate access to client-centered information, services, discussion groups, and alerts. Over time the portal will improve as recommendations by the user groups are adopted and the site content grows. Specifically the client portal will offer and improve access to the following:

1. **Electronic Access to Client-Centered Information**
   a. Healthcare summary (Continuity of Care document) updated regularly
   b. Summary of services and treatment plans
   c. Secured site to update client profile/ healthcare information for providers
   d. Peer-created discussion forums

2. **Access to Information and Electronic Communication Tools**
   a. Request official medical record
   b. Clients Rights Handbook
   c. Links to additional service providers and resource sites
   d. 800 numbers for information or complaints
   e. Links to Center message boards Like Twitter and Facebook

3. **Alerts and Notifications**
   a. Link to request email notices
      i. Appointment reminders
      ii. Medication reminders
      iii. Emergency contact
   b. Spindletop holiday schedule or emergency closings
   c. New services and current events
   d. Satisfaction surveys

**Relation to regional goals:** This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

**Challenges:** Developing the client access portal will require the expertise of numerous outside vendors and will take up to one year to purchase and install equipment and configure the
software. By using industry standard software like MS-SharePoint and contracting with qualified partners and consultants, we will ensure that the platform is developed expeditiously and securely.

Training service providers and clients to use an internet-ready device (tablet pc) to access the client portal will require hands-on instruction in a structured classroom environment. To meet this challenge, one full-time project manager will be hired to provide comprehensive training to staff and clients, act as the liaison between the center’s clinical and IT staff, develop and maintain the client portal, and be the site’s webmaster.

5-Year Expected Outcomes: The expected outcome of this program by the end of demonstration year 5 is to increase client access to health care information through the development of the client portal and training of 1400 outpatient consumers on its use. Engaging clients in their healthcare management should improve their overall health, and system-wide healthcare costs should decrease.

Starting Point/Baseline:

Spindletop currently has an external website with information that remains fairly static. We also have a Facebook and Twitter presence, but we do little to publicize this for client use. Although we have experience with SharePoint, this is limited to employee secure information and is not client-directed or accessible. Some staff use tablet pc’s but are able to share what they know on a limited basis. Client email addresses are collected when available, but we do not currently use email to disseminate health information.

Rationale:

In an effort to improve client access to healthcare, numerous recent initiatives have been mandated that encourage the use of technology. The strategic plan of the U.S. Department of Health and Human Services’ (HHS) Office of the National Coordinator for Health Information Technology (ONC) identified patients’ participation as a “critical, yet currently underutilized, component in improving health and the overall health care system” and that “the single biggest lever to individual empowerment [over their health care] is access to data.” Healthcare providers have begun to provide systems for electronic distribution of client health information via email or websites; however, one key factor limiting the success of these programs is the assumption that all clients have ready access to a web enabled device or computer. The ONC’s 2011-2015 strategic plan cites that “only 7 percent of Americans have used a web site access their health information online.”

Clients of intensive Medicaid services are often those who have little or no access to the devices (laptops, tablets, or smartphones) that are able to help them find and use healthcare information being provided via the internet. As more and more services and health information are available online, this project would help our clients take charge of their own health and use resources that may have been out of reach to them.

Access to client information in the current healthcare system is fragmented, requires the acquisition of health information to be completed in person, and often limits timely self-directed interventions. A study found that patients who received enhanced levels of healthcare support, including telephone, mail, e-mail, and the internet, had 5.3% lower overall medical costs, 12.5% fewer hospital admissions, and 9.9% fewer pressure-sensitive surgeries. Numerous other studies...
have emphasized the importance of e-health in helping patients actively manage their healthcare. Through the use of a client-centered web portal, information can be shared in a secure and timely manner, thus improving care and reducing costs. Moreover, the training and equipment we provide through this project will be utilized to access other providers and resources both online and in the community which creates additional opportunities for improved outcomes and a better integrated healthcare delivery system.

**Project Components:**

- Hiring a project manager to coordinate the project, train staff and clients, and be the webmaster
- Developing the project plan
- Contracting with outside consultants for website development and hardware installation
- Purchasing equipment for staff and clients to check out; equipment remains the property of Spindletop and will be tracked and have programmed limitations to ensure appropriate usage.
- Training staff and clients on the use of the new tablets to access the client portal, to setup and use email accounts, and on basic use of the internet.
- For ongoing quality improvement, Spindletop will conduct client satisfaction surveys routinely and publish the results utilizing an industry standard electronic survey tool. Comments will be reviewed and used to improve the quality of site content and client satisfaction.

**Milestones:**

For demonstration year 2, the process milestone is to hire the project manager, purchase initial hardware and software, and contract with various professional vendors to install and deploy hardware and software for the client access portal.

In demonstration year 3, the improvement milestones will be to continue development of the portal and purchase additional equipment. Once the site is operational, the project manager will organize a pilot group of staff and clients to help test all equipment, create training materials, and develop portal content.

In DY 4, the improvement milestones will be to train 600 of Spindletop’s behavioral health outpatient client to access healthcare information on the client portal.

In DY 5, the improvement milestone will be a reduction in ED visits for the clients who have been trained to use the client portal in DY3-4; the baseline for the ED visits will be established in DY4. This improvement milestone was selected since the goal of the project is to improve the health of the clients and reduce healthcare costs. Spindletop will continue to train additional clients in DY5.
Unique community needs the project addresses:

The Client Access Portal project proposed in this plan relates to community needs CN.1, CN.16, and CN.17.

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

This client health information access portal would be a new service for Spindletop. No U.S. Department of Health and Human Services funding is received for this program.

Related Category 3 Outcome Measure:

Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores, patients getting timely health information. One of the purposes of this project is for clients to have access to their healthcare information and learn skills that allow them to become more self-sufficient and have more control over their physical and behavioral health. The survey will be designed to produce comparable data on the patient's perspective on care that will allow objective and meaningful assessment of the program in meeting the needs of the clients. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

Relationship to Other Projects:

This project relates to Spindletop’s projects to integrate primary care with behavioral health #096166602.2.1 as physical health information would be available to clients on the web portal; to enhance behavioral health training #096166602.2.3 as providers are trained on using the client portal to support health care; and to utilize peer-to-peer support services #096166602.2.7 as group discussions related to health care are developed.

Relationship to Other Performing Providers' Projects:

Project Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders and emergency room visits. Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Since behavioral health clients have a high incidence of severe illnesses that shorten their life spans by 25 years compared to the general public, any programs that improve their mental and physical health should increase both the length and quality of their lives.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>N/A</th>
<th>Client Health Information Access Portal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.11.3</td>
<td>IT-6.1</td>
<td>N/A</td>
<td>Spindletop Center</td>
</tr>
<tr>
<td>Percent improvement over baseline of patient satisfaction scores-Patients getting timely healthcare information</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-X]: Hire project manager; contract with consultants; purchase initial equipment</td>
<td><strong>Metric 1</strong> [P-X.1]:</td>
<td><strong>Milestone 2</strong> [P-X2]: Develop client portal; purchase additional equipment; train test group</td>
<td><strong>Milestone 3</strong> [I-X]: Train clients on portal</td>
</tr>
<tr>
<td>Goal: Hire project manager, contract with consultants, purchase initial equipment</td>
<td>Baseline/Goal: Develop client portal; purchase additional equipment; train test group of 50 clients</td>
<td>Metric 1 [I-X.1]: Baseline/Goal: 600 MH outpatient clients receiving training</td>
<td>Metric 1 I-X.1: Baseline/Goal: 5% reduction in ED visits for clients receiving training; baseline to be established in DY4</td>
</tr>
<tr>
<td>Data Source: Payroll records, consultant agreements, purchase records</td>
<td>Data Source: Program documentation, purchase records</td>
<td>Data Source: Training documentation</td>
<td>Data Source: Hospital ED admissions</td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $41,422</td>
<td>Year 3 Estimated Milestone Bundle Amount: $46,488</td>
<td>Year 4 Estimated Milestone Bundle Amount: $50,306</td>
<td>Year 5 Estimated Milestone Bundle Amount: $48,433</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5): $186,649*
Texana Center

Pass 1
Project Option 1.12.2 – Expand the Number of Community Based Settings where Behavioral Health Services may be Delivered in Underserved Areas: Enhance Service Availability of appropriate levels of behavioral health care (i.e., applied behavior analysis and speech-language pathology for children diagnosed with autism).

Unique RHP Project Identification Number: 081522701.1.1
Performing Provider Name/TPI: Texana Center / 081522701

Project Description:
Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis, ABA, and speech-language pathology for children diagnosed with autism spectrum disorders, ASD) to expand the number of community based settings where behavioral health services may be delivered in underserved areas.

Provider Description:
Texana Center is the Local Authority for Behavioral Healthcare and Intellectual Developmental Disabilities Services for 6 counties within the RHP 3 area: Austin, Colorado, Fort Bend, Matagorda, Waller and Wharton. Texana Center serves approximately 9,800 people annually (an estimated 7,000 in BH services and 3,000 in IDD services), employs 742, and has an annual operating budget of $39,211,988.

Intervention(s):
This project will develop and implement evidence-based interventions of ABA and SLP in an additional location for children with a diagnosis of ASD. Interventions include assessment, treatment development, and intervention overseen by Board Certified Behavior Analyst, BCBA, and Speech Language Pathologists, SLP, as well as training care givers using ABA.

Need for the Project:
There are increasing numbers of children diagnosed with ASD as evidenced by the latest statistics from the Center for Disease Control indicating 1:88 children have an ASD diagnosis. The Texana Children’s Center for Autism only has 1 setting, currently serving 42 children diagnosed with ASD. Waiting lists in the area range from 30 to 200 per clinic and waits can be up to 2 years or until the child ages out of eligibility. Additionally, early intensive ABA can be costly, exceeding $50,000 per year. This project improves access to needed behavioral health services for low income families, 70-90% of children will be Medicaid eligible.

Target population:
Children with ASD diagnoses or related conditions from the age of diagnosis through the age of 8.

Category 1 expected patient benefits:
Our goal is to increase utilization of community behavioral healthcare (i.e., ABA and SLP services for ASD). Capacity in DY1 was 42 at current site, in DY2 goal is to add 1 additional site and serve 10 children, DY3 24 children, DY4 up to 26 children, and DY5 up to 26 children at the second site. Children will exhaust the 24 month treatment cap and additional children will be admitted to the program, thus resulting in a projected 50 children served by the 1115 waiver through DY5.

Category 3 Outcomes:
The project seeks to increase the quality of life for individuals served. Specifically, these treatments are designed to demonstrate improvements in activities of daily living, increase functional skills, language/communication, social interactions, pre-academic achievement, as well as decrease problem behaviors as measured by an evidence-based and validated assessment tool for children diagnosed with ASD.

Project Valuation:
By providing ABA services to children with autism, it allows for cost avoidance. The current project proposes to serve at least 50 children in years 2-5 with 25-40 hours per week per child of intensive ABA intervention. At 6 hours per day, this will be approximately 1,500 hours of treatment annually per child. Based on the figures derived from the 2007 Chasson study which indicated a $208,500 savings per child, the state of Texas could save $10,425,000 across 18 years of education by providing ABA treatment to these 50 children. This savings exceeds the total listed 5-year valuation for this project. Furthermore, in 1998, Jacobson et al. found that cost savings following intensive ABA are estimated to be from $2,439,710 to $2,816,535 with inflation to age 55 per child served (Jacobson, Mulik, & Green, 1998). Therefore, based on the figures derived from this study, the state of Texas could save $121,985,500 through age 55 for these 50 children by providing early intensive ABA treatment.
Project Option 1.12.2 - Expand the number of community-based settings where behavioral health services may be delivered in underserved areas: Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders)

**Unique RHP Project Identification Number:** 081522701.1.1  
**Performing Provider Name/TPI:** Texana Center / 081522701

**Project Description:**  
*This category 1 project, 1.12.2, will provide specialized behavioral health care services to the complex behavioral health population of children with diagnoses of autism spectrum disorders and related conditions.*

Texana Children’s Center for Autism will add a second location to provide access to Applied Behavior Analysis (ABA) and Speech Language Pathology (SLP) interventions to serve 26 additional children at a time (from a current level of approximately 40 children at a time). This will result in a minimum of 50 additional children to receive this type of service through year 5. These children require 1:1 intensive services for 25-40 hours per week for at least 2 years. Treatment is most effective if initiated before the age of 4 but it is effective for all ages. The proposed age group includes age of diagnosis through age 8. Based on current waiting lists, between 70-90% of children served will be Medicaid eligible. Treatment will be provided in a clinic/day treatment, community, or home setting. Treatment will be limited to up to 24 months per child so that more children can benefit from the program.

The population of children with an autism diagnosis often has key health challenges and multiple issues such as lack of daily living skills, cognitive challenges, and limited support in the community. The State's mental health system provides some minimal services, but can only serve a fraction of the population. The existing behavioral healthcare environment does not provide the necessary range of specialized therapies needed to address the complex needs of a child with autism. Positive healthcare outcomes are contingent on the ability of the patients to obtain services as soon as possible after diagnosis. However, many Texas children are unable to access these much needed services.

There are increasing numbers of individuals diagnosed with Autism Spectrum Disorders (ASD). The latest statistics from the Center for Disease Control (CDC) indicate that 1 in 88 children have a diagnosis of autism. Repeated studies by special tasks forces and others such as the US Surgeon General and the National Autism Standards Project have consistently found that Applied Behavior Analysis (ABA) intervention is the most effective intervention for children with ASD. In fact, research indicates that approximately 50% of children that receive 1:1 intensive ABA before the age of 4 for 25-40 hours a week for at least 2 years will no longer meet the diagnostic criteria for an ASD diagnosis (Howard, et al. 2005). Recent research, including the National Standards Project, emphasizes the importance of empirically based Speech Language Pathology (SLP) intervention in addition to the primary mode of intervention of ABA. With a success rate of 47 percent for early intensive behavioral intervention (Lovaas, 1987), one study found that cost savings following intensive ABA are estimated to be from $2,439,710 to $2,816,535 with inflation to age 55 per child served (Jacobson, Mulik, & Green, 1998).

This project proposes to enhance availability of specialized therapies, ABA and SLP treatment, for children with ASD consistent with best practices (Howard et al. 2005, National...
The innovative care model proposed includes interventions to increase language and communication, social skills, play skills, group participation skills, self-help skills, pre-academics skills, natural environment training, feeding intervention, community skills, pre-vocational skills, school-readiness skills, and parent training. Treatment will be developed and supervised by Board Certified Behavior Analysts (BCBA) and licensed Speech and Language Pathologists. Treatment will be provided in a clinic/day treatment, community, or home setting. Eligible persons are individuals with ASD from the age of diagnosis through the age of 8.

**Major Project Activities, Goals, and Relationship to Regional Goals:**

The major project activity and goal is to provide applied behavior analysis (ABA) and speech language pathology intervention to children diagnosed with autism in underserved areas in order to address the regional goals of increased access to appropriate levels of healthcare, improved quality of care, and enhanced health of clients and families we serve. Research supports that the interventions outlined in this proposal will address these outcomes. Up to 50% of children with an autism diagnosis that receive 25-40 hours per week of intensive ABA beginning before the age of 4 for approximately 2 years achieve post treatment test scores in the normal/average range (Lovaas, 1987; Howard, et. al., 2005).

This project is consistent with several other regional goals. It contributes to development of a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the region, and improves health care outcomes. The project is consistent with the goal of developing a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes. It also increases access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, with more available locations regardless of their ability to pay. This is consistent with the regional goal of improving health for the population and lowering costs through these improvements. Research has shown that if we pay the costs of early intensive ABA as described upfront, the long-term savings far exceed initial costs. A 2007 study indicated that the state of Texas will save $208,500 per child across eighteen years of education with early intensive ABA (Chasson et al). Cost savings following intensive ABA are estimated to be $2,816,535 with inflation to age 55 per child served (Jacobson, Mulik, & Green, 1998).

**Starting Point/Baseline:**

The Texana Children’s Center for Autism currently only has 1 setting. In this setting, Texana currently serves 42 children diagnosed with Autism Spectrum Disorders or related conditions. Twenty of these children are able to access treatment via private funds or private insurance. The remaining twenty-two children are able to access services through an existing grant from the Department of Assistive and Rehabilitative Services, DARS. The Children’s Center for Autism anticipates serving approximately 50 total children by the end of this fiscal year (September 2012-August 31, 2012). These children receive between 15 and 32 hours of intensive ABA per week. Despite this, waiting lists in the area range from 30 to 200 per clinic and waits can be up to 2 years or until the child ages out of eligibility.
The current project will allow us to expand to a second location in year 2 serving up to 26 additional full time (25-40 hours per week) children at a time by year 5. Children will be limited to up to 24 months in the program in order to increase the absolute number of children served. Therefore at least 50 children will be served at the new community-based setting. Texana plans to serve 10 additional clients in year 2; beginning within 90 days of being given approval. Texana projects the ramp up to include seeing 10 children year 2 with one BCBA hired and increase to 24 children year 3 with a second BCBA hired. A BCBA caseload is typically 10-12 clients, so Texana will add to the caseloads in years 4 and 5 with the addition of a University of Houston Clear Lake graduate student under supervision. See table below. There will be only 1 new site across the 5 years as part of this project. Texana has submitted a pass 3 project that will allow for a third location that will serve 14 children at a time and 26 children through year 5.

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of NEW Community-Based Sites where Children are Served (pass 1)</td>
<td>0</td>
<td>1</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Total Cumulative Number of Children Served at NEW Community-Based Site (pass 1)</td>
<td>0</td>
<td>10</td>
<td>24</td>
<td>36</td>
<td>50</td>
</tr>
<tr>
<td>Child Census at NEW Community-Based Site (pass 1)</td>
<td>0</td>
<td>10</td>
<td>24</td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>Children Admitted to NEW Community-Based Site (pass 1)</td>
<td>0</td>
<td>10</td>
<td>14</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>Children Discharged from NEW Community-Based Site (pass 1)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Projected Total Children's Center Census (3 sites: original, pass 1 and pass 3)</td>
<td>42</td>
<td>52</td>
<td>80</td>
<td>84</td>
<td>84</td>
</tr>
</tbody>
</table>

**Challenges and how to address:**

The proposed project faces challenges in more than one area. All anticipated challenges present with viable solutions. First, there is often a shortage of availability of licensed/certified therapists and other qualified staff in underserved areas. As the proposed project is an expansion of an established ABA program which has an association with the University of Houston Clear Lake, therapists can be trained while working in the established location and then moved to the underserved area.

Second, there is a lack of public awareness of available services. Initially, the proposed project will draw referrals from the local Early Childhood Intervention programs and the local Intellectual and Developmental Disabilities Authorities. The plan for public awareness will include information and education to local independent school districts, parent support groups, health/resource fairs, daycares, clinic, and pediatrician offices.

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

The expected outcome for the proposed project is to expand services for children with an autism diagnosis to underserved areas. Families of children with an autism diagnosis would
have available, economically accessible services to meet identified needs through the 1115 waiver program. Children faced with the challenge an autism diagnosis would be given the best possible opportunity to achieve significantly improved quality of life and school readiness skills. Children served will have increased trajectory of skills development and reduced need for special education services resulting in long term cost savings to the state for both special education and other behavioral healthcare services.

**Rationale:** Texana Center selected this project for the following reasons:

- This project is data driven. As previously mentioned, there is an increasing number of individuals diagnosed with Autism Spectrum Disorders (ASD). Current statistics from the CDC indicate that 1 in 88 children have a diagnosis of ASD. In fiscal year 2012, through Strategic Planning, Texana Center recognized the need to shift some resources from adult services to children services. Eighty-five percent of the individuals waiting for eligibility determination are under 21, and are seeking behavior supports and/or respite as a primary service. The 25 school districts in our local area reported that in the 2011-2012 school year, 4,332 students with IDD were served and 2,374 of these children had a diagnosis of ASD. As the number of children diagnosed with ASD increases, the need for treatment also increases. ABA and SLP are the treatments with the most evidence supporting their effectiveness (National Autism Center's National Standards Report, 2009). In 1999, the Surgeon General named ABA, the treatment of choice for children diagnosed with Autism. Lovaas (1987) documented 9/19 or 47% children who received early intensive (40 hr per week) ABA before the age of 4 for at least 2 years had cognitive and language scores in the normal range by age of 6-7 years. Numerous additional studies have supported this finding (e.g. Howard, et. al., 2005).

- This project addresses the needs of the community for expanded behavioral healthcare. RHP CN 2 - Insufficient access to behavioral health care services, resulting in lack of care or delay of care, delivery of inappropriate and insufficient care, unnecessary and preventable complications, and increased demand on criminal justice system. Children with ASD diagnoses in our area frequently never access services due to lack of funding or are placed on a waiting list for 1-3 years or until they age out of eligibility. This is highly detrimental to the trajectory of their future outcomes. Medicaid generally does not pay for this medically necessary treatment, and 70-90% of those served in this waiver program will be Medicaid eligible.

- This project is cost effective. In 1998, Jacobson et al found that cost savings following intensive ABA are estimated to be from $2,439,710 to $2,816,535 with inflation to age 55 per child served (Jacobson, Mulik, & Green, 1998). Additionally, in 2007, Chasson et al results indicate that the state of Texas will save $208,500 per child across eighteen years of education with early intensive ABA.

- Texana center has the experience to implement this project. Since 2004, Texana has been operating an intensive ABA program for children diagnosed with Autism, the Children’s Center for Autism. Texana has the administrative support and clinical expertise as well as the existing infrastructure to ensure a smooth and successful expansion.

Consistent with the DSRIP Category 1.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas, there are no required core project components listed in the menu. Core components from other areas that are included
are: *Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population (children with an autism diagnosis).*

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

The Category 3 Quality Improvement Outcome Measure, IT-10 2 Quality of Life/Activities of Daily Living, relates to the Category 1.12.2 project of increased utilization of community behavioral healthcare services of ABA and SLP for individuals with ASD. These treatments are specifically designed to improve symptoms and function, two essential components of quality of life. Early intensive ABA treatment results in increased language and communication skills, improved social skills, achievement in pre-academic and academic areas, and decreased problem behaviors (Howard et al. 2005). Early intensive ABA as described above can be costly, exceeding $50,000 per year. This project will improve access to needed behavioral health services for low income families; 70-90% of these children will be Medicaid eligible.

Baseline data will be collected during years 2 and 3 using a variety of the below and related assessment tools. One or a combination of 2 or 3 of these tools will be utilized to demonstrate progress during years 3-5 based on baseline data collected during years 2 and 3.

- Demonstrated improvement in quality of life on the Assessment of Basic Language and Learning Skills (ABLLS-R), Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), and/or the Assessment of Functional Living Skills (AFLS). Progress can be measured by examining changes in the student’s scores from one administration to the next (e.g., Goin-Kochel, Myers, Hendricks, Carr, &Wiley, 2007;Sullivan & Perry, 2006). The ABLLS-R and similar tools were selected because they are now commonly used by educators, school personnel, and psychologists to assess and monitor skills of children with autism who are receiving behavior therapy (e.g., Bradley-Johnson, Johnson, & Vladescu, 2008; Goin-Kochel et al., 2007; Schwartz, Boulware, McBride, & Sandall, 2001) and, according to Aman et al. (2004), the ABLLS-R has been selected as an outcome measure by the National Institute of Mental Health Research Units in Pediatric Psychopharmacology and Psychological Intervention Autism Network.

**Relationship to other Projects:**

The development and improvement of services for patients with behavioral health disorders, such as ASD, is a focus of multiple projects throughout the RHP, including those in Category I for expanding access and Category II for developing innovative solutions to priority issues. This project supports expanding specialty care capacity, developing behavioral health crisis
stabilization as alternatives to hospitalization, providing an intervention for targeted behavioral health population to prevent unnecessary use of services in a specified setting, and recruiting, training, and supporting consumers of mental health services to provide peer support services. Texana has both a pass 1 and pass 3 project addressing behavioral health needs in underserved areas for children diagnosed with autism. Texana also has a pass 1 project to address behavioral health crisis services and behavioral health crisis services for individuals with Intellectual and Developmental Disabilities. In addition, Texana has a pass 2 project to improve access to specialty care for infants and toddlers at risk.

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

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from an inpatient unit. This initiative is similar to many others in the sense that it impacts the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs. Intellectual and developmental disabilities (IDD) are a large focus of our community including our local mental health authorities in the region. There are additional initiatives in the RHP plan with a focus on IDD and are represented in the addendum (Region 3 Initiative Grid). The IDD initiatives primarily support outcome measures of patient satisfaction scores, and admission/re-admission rates. Local Authorities for intellectual and developmental disabilities (IDD) services throughout the state are proposing the implementation of projects to improve access to services for individuals with IDD for their respective RHP areas. The Department of Aging and Disabilities Services (DADS) has encouraged local authorities to propose projects to address the needs of the IDD population including ASD. Specifically, Harris County MHMRA is proposing 2 projects that included ABA services, STARS and in-home services. The Andrews Center MHMRA is also proposing ABA services for children with autism.

**Plan for Learning Collaborative:**

Through this project, Texana Center and MHMRA of Harris County will expand the existing collaboration to include monthly telephone conferences to share best practices, new ideas and solutions for the autism intervention project. The established provider meetings will provide an effective forum for gathering input of stakeholders in the project processes. Through this expanded learning collaborative, Texana and participating Local Authorities will share challenges and testing of new ideas and solutions. Additionally, Texana plans to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System as appropriate. Texana’s participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. This exchange will facilitate effective processes, efficient use of resources, and consistent data benchmarking across similar projects statewide.

**Outcome Project Valuation:**

This project addresses a priority need for the population of individuals with ASD to receive intensive ABA and SLP services in the community. One of the goals of this project is to avert
outcomes such as potentially avoidable inpatient admissions and readmissions in settings including general acute and psychiatric hospitals, state supported living centers, and self-contained special education classrooms; to promote wellness and adherence to treatment; to promote independence in the community; and to improve quality of life. The vision will be realized throughout the child's lifetime, however, the reduction in the need for self-contained special education classrooms and in some cases the elimination of the need for special education for children served in this project would be realized during the 4 year DSRIP project.

By providing ABA services to children with autism, it allows for cost avoidance. The current project proposes to serve at least 50 children in years 2-5 with 25-40 hours per week per child of intensive applied behavior analysis intervention. At 6 hours per day, this will be approximately 1,500 hours of treatment annually per child. Based on the figures derived from the 2007 Chasson study which indicated a $208,500 savings per child, the state of Texas could save $10,425,000 across 18 years of education by providing ABA treatment to these 50 children. This savings exceeds the total listed 5-year valuation for this project. Furthermore, in 1998, Jacobson et al. found that cost savings following intensive ABA are estimated to be from $2,439,710 to $2,816,535 with inflation to age 55 per child served (Jacobson, Mulik, & Green, 1998). Therefore, based on the figures derived from this study, the state of Texas could save $121,985,500 through age 55 for these 50 children by providing early intensive ABA treatment.

**Total Five Year Valuation:** $9,105,687

**Resources:**


<table>
<thead>
<tr>
<th>081522701.1.1</th>
<th>1.12.2</th>
<th>N/A</th>
<th>Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texana Center</td>
<td>081522701</td>
<td>5</td>
<td>Quality of Life/Functional Status/ ADL</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Related Category</th>
<th>Outcome Measure(s)</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 1</td>
<td>P-3: Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for additional community-based setting)</td>
<td>Milestone 2</td>
<td>P-6: Establish behavioral health services in new community-based settings in underserved areas</td>
<td>Milestone 3</td>
<td>P-7: Participate in at least bi-weekly interactions (meeting, conference calls, or webinars) with other providers, and the RHP to promote collaborative learning around shared or similar projects. Participation includes: 1) sharing challenges and any solutions; 2) sharing results and quantitative improvement that the provider is testing; and 3) identifying a new improvement and publically commit to testing it in the week to come.</td>
</tr>
<tr>
<td>Metric 1</td>
<td>P-3.1: Manual of operations for the project detailing administrative protocols and clinical guidelines Baseline- existing protocols for the current setting Goal-to modify/customize these protocols and create any necessary subsequent protocols for the additional settings Data Source: Administrative protocols; clinical guidelines</td>
<td>Metric 2</td>
<td>P-6.1: Number of new community based settings where behavioral health services are delivered (i.e. applied behavior analysis and speech and language</td>
<td>Metric 2</td>
<td>P-8.1: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
</tr>
<tr>
<td>Milestone 1</td>
<td>Estimated Incentive Payment (maximum amount): $882,194.33</td>
<td>Metric 2</td>
<td>P-8.2: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and</td>
<td>Metric 2</td>
<td>P-8.2: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and</td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan
Region 3

643
| 081522701.1.1 | 1.12.2 | N/A | Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders) |

**Texana Center**

| Related Category 3 Outcome Measure(s): | 081522701.3.1 | J1-10.2 | Quality of Life/Functional Status/ADL |

| Year 2 (10/1/2012 – 9/30/2013) | Year 3 (10/1/2013 – 9/30/2014) | Year 4 (10/1/2014 – 9/30/2015) | Year 5 (10/1/2015 – 9/30/2016) |

- **Baseline/Goal:** 1 setting  
- **Goal:** add 1 additional setting to total 2 settings  
- **Data source:** Project Documentation  
- **Milestone 2 Estimated Incentive Payment (maximum amount):** $882,194.33

#### Milestone 3 [I-11]: Increased utilization of community behavioral healthcare (i.e., ABA and SLP services for autism).

- **Metric 1 [I-11.1]:** Percent utilization of new community behavioral healthcare services.  
  - **Baseline:** 0 children at new setting  
  - **Goal:** 10 children served will be funded by the expansion
  - **Data Source:** Claims data and encounter data

- **Milestone 3 Estimated Incentive Payment:** $882,194.33

#### Year 2 Estimated Milestone Bundle Amount: $2,646,583

- **Year 3 Estimated Milestone Bundle Amount:** $2,073,996

- **Year 4 Estimated Milestone Bundle Amount:** $2,195,800

- **Year 5 Estimated Milestone Bundle Amount:** $2,189,308

- **Milestone 6 Estimated Incentive Payment: $1,097,900

- **Milestone 7 Estimated Incentive Payment: $1,097,900

- **Milestone 8 Estimated Incentive Payment: $1,094,654

- **Milestone 9 [I-11]:** Increased utilization of community behavioral healthcare (i.e., ABA and SLP services for autism).

- **Metric 1 [I-11.1]:** Percent utilization of new community behavioral healthcare services.  
  - **Baseline:** 36 children cumulative children based on DY 4  
  - **Goal:** 50 cumulative children served will be funded by the expansion
  - **Data Source:** Claims data and encounter data

- **Milestone 7 Estimated Incentive Payment:** $1,094,654

**Regional Healthcare Partnership Plan**

**Region 3**
<table>
<thead>
<tr>
<th>081522701.1.1</th>
<th>1.12.2</th>
<th>N/A</th>
<th>Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texana Center</td>
<td>081522701</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s):</strong></td>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
</tr>
<tr>
<td>Quality of Life/Functional Status/ ADL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</td>
<td><strong>(add milestone bundle amounts over Years 2-5): $9,105,687</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Project Option 1.3.1- Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Behavioral Healthcare Crisis Center for six-county area

**Unique RHP Project ID:** 081522701.1.2  
**Performing Provider Name/TPI:** Texana Center / 081522701

**Project Summary:**

**Provider:** Texana Center is the Local Authority for Behavioral Healthcare and Intellectual and Developmental Disability Services for six counties within RHP 3: Austin, Colorado, Fort Bend, Matagorda, Waller, and Wharton. Texana Center serves approximately 9,800 individuals annually (an estimated 7,000 in BH services and 3,000 in IDD services), employs 742, and has an annual operating budget of $39,211,988.

**Intervention(s):** This project will develop an 8 bed 48-hour extended observation unit and a 14 bed crisis residential unit where individuals in crisis may go to be assessed and stabilized by providing crisis intervention services. This center will provide a clinically appropriate setting and less costly alternative to hospital inpatient stays, emergency room visits, and jail.

**Need for the project:** Currently, there is not a behavioral healthcare crisis center or behavioral healthcare emergency services center located in the six county service area. A crisis center is a less costly and more clinically appropriate alternative to hospital emergency rooms, state hospital inpatient beds, and jails. At the present time, there are no other alternatives in the community.

**Target Population:** The target population includes all Medicaid and indigent patients in crisis and in need of assessment and stabilization services.

**Category 1 or 2 expected patient benefits:** Our DY4 goal is to improve upon DY3 by 3% and for DY5 an additional improvement of 3% over DY4. Over the course of DY3-DY5, this center will see a minimum of 1,872 patients.

**Category 3 outcomes:** IT-9.4 Other Outcome Improvement Target, standalone measure using an inpatient criteria assessment to determine preventable admissions admitted to the crisis center. Each individual admitted to the observation unit will be screened using an inpatient criteria assessment tool used by the state hospital system. For individuals meeting inpatient criteria, they will be admitted to the observation unit, provided crisis intervention services and medication and then reassessed using the same tool 24 hours later. If the individual no longer meets inpatient criteria, the individual will count as a preventable admission. If the individual meets criteria, arrangements will be made for inpatient admission at a state hospital. This cumulative number will be the numerator and the denominator will be the total number admitted to the observation unit. We will look for 3% improvement each year. We estimate the baseline to be approximately 40 per month on average but will use DY3 to refine this baseline. We believe this measure will show the true transformation we are trying to achieve as opposed to just trying to reduce admissions to the state hospital. Currently, many Fort Bend County residents travel to
Harris County and are admitted in Harris County unbeknown to us. Once the crisis center is operational, these individuals will stay in Fort Bend County where a percentage will be admitted to an inpatient unit. This measure will give us the ability to measure true preventable admissions as opposed to trying to decrease state hospital admissions.
Identifying Project and Provider Information:

**Title of the Project:** Behavioral Healthcare Crisis Center  
**RHP Project Identification Number:** 081522701.1.2  
**Performing Provider Name:** Texana Center  
**Texas Provider Identifier:** 081522701

**Project Description:**

Texana Center, the local mental health authority, proposes to start a behavioral healthcare crisis center to serve a six county area (Fort Bend, Matagorda, Wharton, Colorado, Austin, and Waller Counties). The center will include an 8 bed 48-hour extended observation unit and a 14 bed crisis residential unit where individuals in crisis may go to be assessed and stabilized. The project number is 1.13.1 – Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

When an individual lacks the appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the situation. Sometimes the choice comes down to the ER, jail or inpatient hospital bed. Crisis stabilization services can be developed that create alternatives to these less desirable settings. While hospitalization provides a high degree of safety for the person in crisis, it is very expensive and is often more than what is needed to address the crisis. Community based crisis alternatives can effectively reduce expensive and undesirable outcomes, such as preventable inpatient stays. For example, state psychiatric hospital recidivism trended downward coincident with implementation of crisis outpatient services in some Texas communities. The percent of persons readmitted to a Texas state psychiatric hospital within 30 days decreased from 8.0% in SFY2008 (before implementation of alternatives) to 6.9% in SFY2011².

Currently, there is not a behavioral healthcare crisis center or behavioral healthcare emergency services center located in the six county service area. A crisis center is a less costly and more clinically appropriate alternative to hospital emergency rooms, inpatient beds, and jails. At the present time, there are no other alternatives in the community. With the exception of geriatric-psychiatric units in local general hospitals, there are also no inpatient psychiatric beds in the service area. Patients requiring hospitalization are transported to Austin State Hospital in Austin, Texas (170 miles away) or if the patient has a payer source, to a private psychiatric hospital in Houston. This sometimes occurs because of the lack of other stabilization options in the service area primarily, observation, residential and/or respite beds.

In the largest county served by the performing provider, Fort Bend County, approximately 20% of the Fort Bend County jail population has a serious mental illness. Due to the lack of alternatives for community evaluation and treatment, these individuals are often booked into the jail so they will be held in a safe environment where they will receive the limited pharmacological management services provided by the jail. Local emergency rooms also must house individuals for extended periods of

---

² *Psychiatric Services* November 2011, Volume 62, No. 11; ps.psychiatryonline.org
time (up to 96 hours) as there are no other local options available and many times no inpatient beds available in the state hospital system.

By having a place to safely house individuals experiencing a behavioral healthcare crisis, we can avoid more costly options of extended stays in hospital emergency rooms and jails. In addition, receiving the most clinically appropriate intervention in the least restrictive setting ensures the maximum potential for successful long term treatment and recovery.

Extended observation units are designed to provide emergency stabilization to individuals experiencing a behavioral healthcare crisis in a secure and protected environment with immediate access to emergent or urgent medical evaluation and treatment. Individuals are provided appropriate and coordinated transfer to a higher level of care if and when needed. Many times, a higher level of care can be avoided due to the immediate intervention offered in the observation unit.

Crisis residential services provide short-term, community-based residential, crisis treatment to persons who may pose some risk of harm to self or others and who may have fairly severe functional impairment. Crisis residential facilities provide a safe environment with staff on site at all times. However, these facilities are designed to allow individuals to come and go and therefore do not accept individuals who are court ordered committed for treatment. Recommended maximum length of stay is 14 days and the average length of stay is between 3 and 7 days.

The 5-year expected outcome of this project is to provide alternatives to hospitalization, emergency rooms, and incarceration and therefore reduce the events in these settings. Every patient seen the crisis center is a potentially preventable admission to one of the current available settings. Not only will this reduce costs in inappropriate settings, it will improve the outcome and potential for recovery for the patient.

While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following which is consistent with this project’s goals:

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

Texana Center, the performing provider currently does not have space in existing facilities to create this crisis center. However, an existing building for sale has been located. Texana Center proposes to purchase and renovate the building by using existing funds and fund-raising for the purchase price and cost of renovations. This project would be modeled after an existing 2011 American Psychiatric
Association Gold Achievement Award² winning facility located in Lufkin, Texas and operated by the Burke Center. The identified facility is also close to the Texana Center at Rosenberg Behavioral Healthcare Clinic which will provide back-up staffing support and cost efficiencies by sharing staff (i.e. psychiatrists.) In addition, this location provides easy access for all six counties as it is located two blocks from Interstate Hwy. 59. Stakeholders have voiced an easily accessible location for this proposed facility as a primary concern. The location proposed alleviates the stakeholder’s concerns. Texana Center plans to purchase the building and begin renovations as soon as the plan is approved and be ready to open doors at the beginning of DY3.

Starting Point/Baseline:

There are currently no patients serviced by the crisis center as it does not exist as an option in the community. Texana Center anticipates serving approximately 50 individuals per month or 600 per year in the first year the crisis center is open.

Rationale:

The population of the six counties included in this project is over 800,000 and extends over 6,000 square miles. The significant growth rate in both Fort Bend and Waller counties increases the population by 25,000 to 30,000 annually. Having virtually no inpatient beds or crisis center for a region this size means there is no place for these individuals to go. These patients often end up for extended periods in local hospital emergency rooms and/or the jail as a last resort. The closest psychiatric inpatient facilities are located in Harris County, fairly close to parts of Fort Bend and Waller Counties but increasingly distant from other rural counties. These facilities are often at capacity as well as the state hospital system. The psychiatric hospitals in Harris County also do not have beds for uninsured, indigent patients. For these patients, the wait in the emergency room is even longer.

The most recent Needs Assessment of Fort Bend County conducted by the Lyndon Baines Johnson School of Public Affairs in the summer of 2011 states that the lack of services for the mentally ill has resulted in “mental health becoming a law enforcement issue.”³

Texana Center has worked very closely over the last five years with the Sheriff’s Office Detention and Patrol, Fort Bend NAMI, Mental Health America – Fort Bend, Adult Probation, and numerous other organizations to identify the gaps in service and work on solutions. One of the primary gaps identified by this group is a “place” to take individuals other than the hospital emergency rooms and jails. In addition, throughout the collaborative RHP process, stakeholders have ranked a crisis center as the priority for this service area.

The unique community need this project addresses is CN2 – Insufficient access to behavioral healthcare services, resulting in lack of care or delay of care, delivery of inappropriate and insufficient

² Psychiatric Services November 2011, Volume 62, No. 11: ps.pyschiatryonline.org
care, unnecessary and preventable complications, and increased demand on the criminal justice system.

Although a great deal of work has already been done around the core components of this project, Texana Center will use DY2 to finalize these core components. These components are as follows:

- Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps. (Since stakeholders have been meeting for the last 4 – 5 years, this component has already been fulfilled.)
- Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria, and discharge criteria for each service.
- Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises stabilization alternatives that will meet the behavioral health needs of the patients.
- Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.

Texana Center will use DY3-DYS to conduct quality improvements for the project as described in the following core component.

- Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

For this project, Texana Center has selected the following process milestones and metrics. These were chosen to ensure core components, some of which have already been fulfilled, are completed and documented appropriately.

- **P-2** – Conduct mapping and gap analysis of current crisis system.
  - Metric: Produce a written analysis of community needs for crisis services.
- **P-3** – Develop implementation plans for needed crisis services.
  - Metric: Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community based on gap analysis and assessment of needs.
- **P-4** - Hire and train staff to implement identified crisis stabilization services.
  - Metric: Number of staff hired and trained.
- **P-5** – Develop administration of operational protocols and clinical guidelines for crisis services.
  - Metric: Completion of policies and procedures.
- **P-9** – Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around similar or shared projects.
  - Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.
Since this is a start-up project and these services are not available, all of these milestones/metrics are necessary for a successful project.

In addition, the following improvement milestone and metrics were chosen.

- I-12 – Utilization of appropriate crisis alternatives.
  - Metric: 3% increase in utilization of appropriate crisis services over baseline DY3.

This milestone was chosen to ensure the crisis center is being used appropriately in lieu of hospital emergency rooms and jails.

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

Currently, the Category 3 Outcome Measure to be chosen falls within OD-2-Potentially Preventable Admissions and/or OD-3 Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs). Texana Center needs to identify data sources (hospitals) and processes to obtain the data in order to make a data-driven decision for a specific outcome measure. By focusing on these outcome measures, low income populations with no funding source for these services will have a place to go in the local community which will allow them to remain close to natural supports which will help prevent admissions and readmissions into psychiatric hospitals.

**Relationship to Other Projects:**

This project is very closely tied with the creation of a law enforcement Crisis Intervention Team proposed by Fort Bend County. Once a law enforcement team is trained to recognize mental illness and appropriate law enforcement interventions to use for this population, they must have a place to take these individuals other than the jail and emergency rooms for complete evaluation and assessment.

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

Numerous community needs assessments reflect an extreme need for behavioral health services to include outpatient treatment centers, crisis stabilization units, inpatient beds, and much more. The lack of funding as well as complexity of the regions patient base has limited the amount of behavioral health treatments available to our region and continues to drive cost in emergent and inpatient situations. The Crisis Stabilization Unit has a direct correlation to all behavioral health programs recommended in the RHP plan and will be a focus of two of the largest Local Mental Health Authorities of our region. Both CSU’s share the outcome measures of mental health admissions and readmissions, and improvement of patient satisfaction scores. The Region 3 Initiative Grid attached in the addendum reflects the direct relationships of the this initiative.

**Plan for Learning Collaborative:**

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

**Project Valuation:**

This project addresses a major need in the community—a “place” for individuals to go other than the hospital emergency rooms and jails and to avoid inpatient stays in psychiatric hospitals. This project was valued using a medical economists’ analysis to determine average savings per acute per year care episode for individuals treated in a residential setting as opposed to a hospital. The study was completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research. Based on this analysis, the value of the program, per acute care episode is $17,504 or $1,750,392 per 100 persons served. The study also indicates that additional cost savings may be expected. Based on this and the projected volume over three years of 1,800 persons served, the valuation for this project is $31,507,056 which is significantly more than twice the value placed on this project.
### Behavioral Healthcare Crisis Center

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
| **Milestone 1** [P-2]: Conduct mapping and gap analysis of current crisis system.  
**Metric 1** [P-2.1]: Produce a written analysis of community needs for crisis services.  
Data Source: Written plan | **Milestone 3** [P-4]: Hire and train staff to implement identified crisis stabilization services.  
**Metric 1** [P-4.1]: Number of staff hired and trained.  
Data Source: a. Staff rosters and training records;  
b. Training curricula | **Milestone 5** [P-9]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.  
**Metric 1** [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organize by the RHP.  
Data Source: Documentation of semiannual face-to-face meetings including meeting agendas, slides from presentations, and/or meeting notes. | **Milestone 7** [P-9]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.  
**Metric 1** [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organize by the RHP.  
Data Source: Documentation of semiannual face-to-face meetings including meeting agendas, slides from presentations, and/or meeting notes. |
| **Milestone 2** [P-3]: Develop implementation plans for needed crisis services.  
**Metric 1** [P-3.1]: Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community based on gap analysis and assessment of needs.  
Data Source: Written plan | **Milestone 4** [P-5]: Develop administration of operational protocols and clinical guidelines for crisis services  
**Metric 1** [P-5.1]: Completion of policies and procedures.  
Data Source: Internal policies and procedures documents and operations manual. | **Milestone 6** [I-12]: Utilization of appropriate crisis alternatives  
**Metric 1** [I-12.1]: 3% increase in utilization of appropriate crisis alternatives based on a baseline of an average of 50 per month  
Goal: Avg. of 54 per month | **Milestone 8** [I-12]: Utilization of appropriate crisis alternatives  
**Metric 1** [I-12.1]: 3% increase in utilization of appropriate crisis alternatives. |

**Milestone 1 Estimated Incentive Payment**: $885,471  
**Milestone 2 Estimated Incentive Payment**: $885,471  
**Milestone 3 Estimated Incentive Payment**: $1,672,429  
**Milestone 4 Estimated Incentive Payment**: $1,672,429  
**Milestone 5 Estimated Incentive Payment**: $1,760,681  
**Milestone 6 Estimated Incentive Payment**: $1,669,468  
**Milestone 7 Estimated Incentive Payment**: $1,669,468
### BEHAVIORAL HEALTHCARE CRISIS CENTER

<table>
<thead>
<tr>
<th>081522701.1.2</th>
<th>1.13.1</th>
<th>1.13.1.A-E</th>
<th>Texana Center</th>
<th>081522701</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 3</td>
<td>081522701.3.2</td>
<td>IT-2.13</td>
<td>Other Admissions Rate</td>
<td></td>
</tr>
<tr>
<td>Outcome Measure(s):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Outcome</th>
<th>Data Source</th>
<th>Milestone 6 Estimated Incentive Payment</th>
<th>Milestone 8 Estimated Incentive Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Other Admissions Rate</td>
<td>Data Source: Claims, encounter, and clinical record data</td>
<td>$1,760,681</td>
<td></td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>which has been determined by analyzing current screening data. Goal: Avg. of 52 per month</td>
<td>Data Source: Claims, encounter, and clinical record data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
<td>Milestone 8 Estimated Incentive Payment: $1,669,468</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $1,770,942</th>
<th>Year 3 Estimated Milestone Bundle Amount: $3,344,858</th>
<th>Year 4 Estimated Milestone Bundle Amount: $3,521,362</th>
<th>Year 5 Estimated Milestone Bundle Amount: $3,338,935</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $11,976,097**

*Add additional projects using same format above*
Texana Center
Pass 2
**Category 1: Infrastructure Development**

**Project Option 1.9.2: Expand Specialty Care Capacity: Improve access to specialty care.**

**RHP Project Identification Number:** 081522701.1.3

**Performing Provider Name:** Texana Center

**Texas Provider Identifier:** 081522701

**Project Description:** Establish or expand initiatives to increase the availability of targeted specialty care providers for infants and toddlers 0-3 years old who exhibit mild developmental delays or have a recognized risk factor that puts them at risk of developmental delay.

**Provider:** Texana Center is the Local Authority for Behavioral Healthcare and Intellectual Developmental Disabilities Services for 6 counties within the RHP 3 area: Austin, Colorado, Fort Bend, Matagorda, Waller and Wharton. Texana Center serves approximately 9,800 people annually (an estimated 7,000 in BH services and 3,000 in IDD services), employs 742, and has an annual operating budget of $39,211,988.

**Intervention:** This project will implement a system of early identification and delivery of therapeutic services that blends the best aspects of private therapy and a natural environment based model and includes social work and/or monitoring by a child development specialist to support parental involvement and supplement the number of clinical hours recommended.

**Need for the project:** Currently there is no unified program for children under the age of three years available to provide comprehensive services to children with developmental delays that do not qualify for Early Childhood Intervention services or children with established risk factors for developing delays.

**Target population:** This project will serve children and families in Austin, Colorado, Fort Bend, Matagorda, Waller and Wharton Counties and coordinate with the Region III Educational Service Center ECI and Project GROW ECI programs.

**Category 1 expected patient benefits:** This project will provide a minimum of 216 visits to deliver therapeutic services in DY 2 to establish a baseline. The number of visits will be increased to a minimum of 3,600 visits in DY 3, 4,800 visits in DY 4, and 6,000 visits in DY 5. Children receiving therapeutic interventions through this project will have an increased likelihood of age appropriate skill development and a decreased likelihood of needing continued therapy or IDEA Part B special education services at age 3.

**Category 3 outcomes:** IT-11.1: Our goal is to provide interventions and supports to children 0-3 years with developmental delays of 15%-24% on standardized testing or established risk factors. Children receiving services will have an increased likelihood of exiting services with developmental skills within normal limits thereby reducing or eliminating the need for continued specialized therapy or IDEA Part B special education services at age 3.

**Valuation:** The proposed project plans to make 216 visits to deliver therapeutic services during demonstration year 2, establishing a baseline and creating a potential savings up to $427,584 to local school districts for those children. Demonstration years 3-5 plan for an increase in the numbers of enrolled children for a total of over 14,000 visits to deliver therapeutic services. This represents services to a total of approximately 324 children and a savings on preschool special education services of $4.3 million.
Project Option 1.9.2: Improve access to specialty care- Therapeutic Intervention for Infants and Toddlers at Risk

Unique RHP Project ID: 081522701.1.3 / Pass 2
Performing Provider Name / TPI: Texana Center / 081522701

Project Description:
This category 1 project, 1.9.2 will increase the capacity to provide specialty care services (occupational, physical, behavior, and speech therapy) and the availability of targeted specialty providers to better accommodate the high demand for specialty care services so that patients have increased access to care.

The time between birth and 36 months of age is a critical developmental period\(^1\) when the neural circuits of a child’s brain are most flexible and subject to change\(^2\). Intervention provided to children during this critical period is likely to be more effective and less costly\(^3\) and can decrease the need for special education and related services when a child enters school\(^4\). *Voices for America’s Children* states that children, who start school behind, particularly on more than one dimension of school readiness, have difficulty catching up\(^5\). Children who fall behind in oral language in the years before formal schooling are less likely to be successful beginning readers and their achievement lag is likely to persist\(^6\). While not every child who experiences mild developmental delays or is at risk for delays will need special education services at school age, those who receive therapeutic supports at an early age have an increased likelihood of being “school ready.” The per-pupil expenditures for special-education students can be estimated to be near double the per-pupil expenditures for general-education students\(^7\).

This project will implement a system of early identification and delivery of therapeutic services that blends the best aspects of private therapy and a natural environment based model and includes social work and/or monitoring by a child development specialist to support parental involvement. Modeled on Department of Assistive and Rehabilitative Services Early Childhood Intervention (ECI) program\(^8\), recognized by Medicaid as cost efficient, the proposed project would establish procedures for accepting referrals from local ECI programs for children with developmental delays of 15%-24% based on standardized testing or risk factors not qualifying for ECI services, as well as accepting referrals from community resources or families and assessing the need for intervention and support. Children identified by the proposed project as meeting eligibility for ECI services would be referred to the appropriate local ECI program.

---

1 Source: [www.oif.org/site/DocServer/EarlyIntervention](http://www.oif.org/site/DocServer/EarlyIntervention)
2 Source: nectac website: [www.nectac.org](http://www.nectac.org)
3 Source: nectac website: [www.nectac.org](http://www.nectac.org)
4 Source: [www.oif.org/site/DocServer/EarlyIntervention](http://www.oif.org/site/DocServer/EarlyIntervention)
5 Rothstein, R. (2004). *Class and schools: Using social, economic, and educational reform to close the black-white achievement gap.*
8 Source: Department of Assistive and Rehabilitative Services Early Childhood Intervention website: [www.dars.state.tx.us/ecis](http://www.dars.state.tx.us/ecis)
Therapy services will be provided in a center-based setting to maximize both personnel and fiscal resources. Families without transportation or living in an area without easy access to a program site, will be eligible for home-based therapy services. Home visits will be made by social workers and/or child development specialists to monitor progress and functionality in the natural environment as well as to support parents as their child’s first and most important teacher.

**Goals and Relationship to Regional Goals:**
- To develop a unified system of therapeutic services and supports for infants and toddlers, 0-3 years old, who have established risk factors for developmental delay or who already demonstrate a mild delay of 15%-24% on a standardized test.
- To provide necessary services and supports to very young children and increase the chance of age appropriate development and decrease potential eligibility for IDEA Part B services at age 3 years.
- To increase access to services and supports to families who are uninsured, underinsured, who live in rural areas with limited available resources or who desire a family centered service model rather than a medical model of services.

The above project goals meet the Regional Goal to “increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition regardless of where they live or their ability to pay.”

**Challenges and how to address:**
The proposed project faces challenges in more than one area. All anticipated challenges present with viable solutions.
- Availability of licensed therapists in rural areas: as the proposed project will serve a 6 county area, staff serving more populated/urban areas will travel to rural areas if a shortage of available, licensed therapeutic staff is identified.
- Maximizing staff and funding resources for greatest efficiency: the proposed project will offer a blend of center-based services and home-based services. While center-based services make most efficient use of staff time and program economic resources, home-based services increase access for families without transportation and promotes family involvement.
- Public awareness of available services: initially, the proposed project will draw referrals from the local Early Childhood Intervention programs to serve those children determined ineligible for ECI services but still showing delays or having risk factors. A joint plan for public awareness will be developed and implemented with the two ECI programs serving the 6 county catchment area.
- Documentation and record keeping in a large geographic area: Texana will support electronic note submittal and all reimbursement activities for the proposed project. All staff will have assigned laptop computers and any signature or portable copiers necessary for efficient business use.

**5-Year Expected Outcome for Provider and Patients:**
The expected outcome for the proposed project is to become a sister program to the two ECI programs serving the 6 county area. Families of children with established developmental risk

---

factors or developmental delay would be assured of available, economically accessible services to meet identified needs through the waiver program if a child is ineligible for ECI services. All infants and toddlers faced with challenges to typical development would be given the best possible opportunity to be age appropriate and school ready on aging out of the proposed project.

Starting Point/Baseline:

Currently there is no unified program for children under the age of three years available to provide comprehensive services to children with developmental delays that do not qualify for Early Childhood Intervention services or children with established risk factors for developing delays.

This project will serve children and families in Austin, Colorado, Fort Bend, Matagorda, Waller and Wharton Counties and coordinate with the Region III Educational Service Center ECI and Project GROW ECI programs. The estimated population of children 0-3 in the six counties served is 21,450\(^{10}\). Approximately 54% of children (11,583 children) 0-3 years old in the six county catchment area are Medicaid enrolled.\(^{11}\) Texas’ rate of uninsured children stands at 14%. Applied to the 0-3 population of the six county area, 3,003 children are uninsured. It is estimated that at least 3% of this population has developmental delays or established risk factors, but local ECI programs qualified 8% fewer children referred during the current fiscal year than were qualified in FY 2011 due to the narrowing of eligibility.

It is estimated that this project will make 216 visits to deliver therapeutic services in DY 2 as part of establishing a baseline for services. During DY 3, 4, and 5 additional children will be enrolled to bring the average number of visits to deliver therapeutic and support services to 3,600, 4,800, and 6,000. As funding and staffing patterns allow, additional children will be enrolled to maximize services.

Rationale:

Texana Center selected this project for the following reasons:

- This project addresses the needs of the community for expanded access to specialty services (RHP CN.2). At the direction of the Texas Legislature, eligibility for Early Childhood Intervention (ECI) services was narrowed starting in FY 2012 with a goal of reducing the number of children served by 8.4%\(^{12}\). With this narrowing of eligibility, ECI identifies a significant number of children who display developmental delays, but less than the 25+% delay that qualifies them for ECI services. The Early Childhood Intervention program hosted by Texana Center has seen a decrease in total number of children enrolled for services of 9% in FY 2012. The total children referred for services that were determined eligible and were enrolled decreased by 8%. In addition, children identified as being at-risk for developmental delay due to prematurity or prenatal drug exposure are not eligible for ECI services without first developing a qualifying delay\(^{13}\). Families of these children have only two options: do

\(^{10}\) US Census 2010
\(^{11}\) [http://www.hhsc.tx.us/research/MedicaidEnrollment/ME/201207.html](http://www.hhsc.tx.us/research/MedicaidEnrollment/ME/201207.html)
\(^{12}\) Source: Department of Assistive and Rehabilitative Services Early Childhood Intervention website: [www.dars.state.tx.us/ecis](http://www.dars.state.tx.us/ecis)
\(^{13}\) Texas Administrative Code §108.805
nothing until their child is school age, or seek private therapy. Families who are uninsured or under-insured often find the private therapy option financially prohibitive.

- This project is cost effective. Modeled on the proven and successful parental involvement philosophy of Early Childhood Intervention, the cost of delivering therapy services during a child’s enrollment in the proposed project will be ½ of traditional recommendations from private providers. Savings continue to be realized after exiting the proposed project as each child receiving therapeutic interventions and supports as infants or toddlers has an increased likelihood of entering regular education at age 5 rather than special education at age 3. This saves the local school districts $17,816 per child over that two year period.

- Texana Center has the experience to implement this project. Texana Center has a history of successfully operating an Early Childhood Intervention (ECI) program. Texana has the administrative support and clinical expertise as well as the existing infrastructure to ensure an easy and successful expansion of services to include infants and toddlers with milder delays or risk factors.

**Project Components:**

a) Increase service availability with extended hours: as this is a new program, there are not yet any established hours to extend. However, it is planned to establish a flexible schedule to accommodate family’s unique needs.

b) Increase number of specialty clinic locations: each location of operation will increase or establish (if none is available in a given area) access to specialty services in each of the 6 county catchment areas.

c) Implement transparent, standardized referrals across the system: the project will use a single referral system that includes notification of outcome when accepting referrals from local ECI programs or other community referral sources. The project will also make consistent use of an agreed upon referral system when making referrals to other providers for children determined to be eligible for or in need of services from other community resources.

d) Conduct quality improvement for project: as this project rolls out over the 6 county area, it will be implemented using plan-do-study-act (PDSA) principles. Each successive area of service will build on the experiences and lessons learned from the preceding establishment of a service area. Areas of improvement identified will be applied to all services as appropriate, understanding that different geographic areas may have unique challenges and needs. Due to the scope of the project and the need to provide services to all 6 counties, the initial phase of PDSA will necessitate rapid cycle improvement to ensure highest quality outcomes for the entire project. Ongoing quality improvement initiatives will be identified through the examination of data and documentation and consultation/collaboration with consumers and community partners. Given the young age, rapid rate of developmental change and limited time to receive services of the target population, rapid cycle improvement when addressing identified challenges will be key in ensuring enacted improvements benefit the maximum number of children.

**Unique community need identification number the project addresses and how it is a new initiative:**
• CN.2-Inadequate access to specialty care: the proposed project is an expansion to the established Early Childhood Intervention services hosted by Texana Center in 2 of the 6 county (Fort Bend, Waller) service area. It will expand access to available services and supports for infants and toddlers 0-3. It is a new initiative for Texana in 4 of the 6 county area (Wharton, Matagorda, Austin, Colorado) as Texana does not provide services nor host an ECI program that serves this population.

Related Category 3 Outcome Measure(s):
IT-11.1 Improvement in clinical indicators in identified disparity group.

Reasons/rationale for selecting the outcome measure:
The Category 3 Quality Improvement Measure, improvement in clinical indicators, relates to the Category 1.9.2 project of improved access to specialty care (occupational therapy, physical therapy, speech therapy, and behavior analysis/therapy). These therapies are designed to improve the developmental functioning of infants and toddlers with developmental delays and to provide supports to children at-risk, thus preventing future delays. In the private marketplace, each of the therapies often costs in excess of $100 per hour. For families that are uninsured or under insured, the costs are prohibitive. By helping children develop age appropriate skills, they acquire the independence and school readiness that best prepares them for success educationally and socially. By providing parent training and support during service delivery, families feel better able to meet the needs of their child.

It is challenging to find evidenced-based answers to specific questions about assessment and intervention for young children with developmental delays. This project proposes to use the Battelle Developmental Inventory 2nd Edition (BDI-2) to establish eligibility for enrollment and an individual baseline score on each child on entry into services. The developmental test will be administered a second time prior to exiting services. The BDI-2 provides a measure of progress during the preschool years and has been designed to help assess the effects of various intervention strategies for individual children and for groups of children.

Relationship to Other Projects: The development and improvement of programs providing specialty care to all individuals is a focus of multiple projects throughout the RHP, including those in Category 1 expanding access to services for children with autism spectrum disorder (ASD). Identifying and addressing needs in infants and toddlers has the primary goal of decreasing the need for ongoing specialized services but also serves to link children to additional available services meeting a wide variety of needs through existing and expanded programs throughout the state.

Relationship to Other Performing Providers’ Projects in the RHP:
Local Authorities for intellectual and developmental disabilities (IDD) services throughout the state are proposing the implementation of projects to improve access to services for individuals with IDD for their respective RHP areas. The Department of Aging and Disabilities Services (DADS) has encouraged local authorities to propose projects to address the needs of the IDD

population. Both Harris County MHMRA and Andrews Center MHMRA are proposing increased services to children through expanded provision of applied behavioral analysis. Increased access to specialty care (OT, PT, ST, and BCBA) for infants and toddlers with developmental delays is an important component in the continuum of needed services available to individuals provided by Texana Center.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

**Plan for Learning Collaborative:** Texana Center plans to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris County Health Systems as appropriate. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. This exchange will facilitate effective processes, efficient use of resources, and consistent data benchmarking across similar projects statewide.

Texana Center also plans to develop a referral collaboration with Region III Educational Service Center ECI and Project GROW ECI to coordinate the referral processes, ensure appropriate access to services for children referred and monitor the proposed projects progress toward meeting the needs of the identified population.

**Outcome Project Valuation:** This project addresses the need for children to have easy and affordable access to specialty care services (occupational therapy, physical therapy, speech therapy and behavioral intervention). The goal of this program is to avert the need for special education services at age 3 years and increase school readiness and success in kindergarten by intervening early and maximizing developmental scores and early learning.

The proposed project plans to make 216 visits to deliver therapeutic services during demonstration year 2, establishing a baseline and creating a potential savings up to $427,584 to local school districts for those children. Demonstration years 3-5 plan for an increase in the numbers of enrolled children for a total of over 14,000 visits to deliver therapeutic services. This represents services to a total of approximately 324 children a savings on preschool special education services of $4.3 million.

In addition to the savings to community educational systems, Medicaid will realize an immediate savings of 50% on the level of recommended therapy by employing the parent training model of service delivery rather than the medical model of service delivery.
### Related Category 3 Outcome Measure(s):

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

#### Milestone 1 [P-1]: Conduct specialty care gap assessment based on population density and % infant/toddler population.

**Metric 1 [P-1.1]:** Documentation of gap assessment.
- **Baseline/Goal:** estimated number of potential referrals for services.
- **Data Source:** Needs assessment based on US Census, ECI referral/enrollment patterns

**Milestone 1 Estimated Incentive Payment (maximum amount): $487,255**

#### Milestone 2 [P-6]: Develop and implement standardized referral and work-up guidelines.

**Metric 1 [P-6.1]:** Documentation of referral and work-up guidelines.
- **Baseline/Goal:** Existing protocols for current setting.
- **Data Source:** Referral and work-up policies and procedures

**Milestone 2: Estimated Incentive Payment: $487,255**

#### Milestone 3 [P-11]: Launch a specialty care clinic/system of services

**Metric 1 [P-11.1]:** Establish specialty care clinic/system of services.
- **Baseline/Goal:** establish baseline number of children served.
- **Data Source:** documentation of number of children enrolled for services.

**Milestone 3 Estimated Incentive Payment: $519,509**

#### Milestone 4 [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 [I-23.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2).
- **Baseline:** DY 2 deliver projected number of 216 visits to deliver therapeutic services.
- **Goal:** Make 3,600 visits to deliver therapeutic services to enrolled children.
- **Data Source:** Documentation of total visits.

**Milestone 4 Estimated Incentive Payment (maximum amount): $562,182**

#### Milestone 5 [P-19]: Participate in at least bi-weekly interactions with other providers, and the RHP to promote collaborative learning around shared or similar projects.

**Metric 1 [P-19.1]:** Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.
- **Data Source:** Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.

**Milestone 5 Estimated Incentive Payment (maximum amount): $562,182**

#### Milestone 7 [P-19]: Participate in at least bi-weekly interactions with other providers, and the RHP to promote collaborative learning around shared or similar projects.

**Metric 1 [P-19.1]:** Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.
- **Data Source:** Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.

**Milestone 7 Estimated Incentive Payment (maximum amount): $541,249**

---

**Performing Provider:** Texana Center

**TPI:** 081522701

**Outcome Measure(s):**

- **081522701.3.4 IT 11.1 Potentially Preventable Admissions**

**Year 2**

(10/1/2012 – 9/30/2013)

- **Milestone 1 Estimated Incentive Payment (maximum amount): $487,255**

**Year 3**

(10/1/2013 – 9/30/2014)

- **Milestone 2: Estimated Incentive Payment: $487,255**

**Year 4**

(10/1/2014 – 9/30/2015)

- **Milestone 3 Estimated Incentive Payment: $519,509**

**Year 5**

(10/1/2015 – 9/30/2016)

- **Milestone 4 Estimated Incentive Payment (maximum amount): $562,182**

- **Milestone 5 Estimated Incentive Payment (maximum amount): $562,182**

- **Milestone 7 Estimated Incentive Payment (maximum amount): $541,249**

---

**Regional Healthcare Partnership Plan**

**Region 3**

---

664
<table>
<thead>
<tr>
<th>Year</th>
<th>Outcome Measure(s)</th>
<th>Metric</th>
<th>Baseline</th>
<th>Goal</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>081522701.3.4</td>
<td>IT 11.1</td>
<td>DY 2 deliver projected number of 216 visits to deliver therapeutic services.</td>
<td>Make 4,800 visits to deliver therapeutic services to enrolled children for reporting period</td>
<td>Documentation of total visits.</td>
</tr>
<tr>
<td>Year 3</td>
<td>081522701.3.4</td>
<td>IT 11.1</td>
<td>DY 2 deliver projected number of 216 visits to deliver therapeutic services.</td>
<td>Make 6,000 visits to deliver therapeutic services to enrolled children for reporting period</td>
<td>Documentation of total visits.</td>
</tr>
<tr>
<td>Year 4</td>
<td>081522701.3.4</td>
<td>IT 11.1</td>
<td>DY 2 deliver projected number of 216 visits to deliver therapeutic services.</td>
<td>Make 6,000 visits to deliver therapeutic services to enrolled children for reporting period</td>
<td>Documentation of total visits.</td>
</tr>
</tbody>
</table>

**Milestone 4 Estimated Incentive Payment:** $519,509

**Milestone 6 Estimated Incentive Payment (maximum amount):** $562,182

**Milestone 8 Estimated Incentive Payment (maximum amount):** $541,249

**Year 2 Estimated Milestone Bundle Amount:** $974,511

**Year 3 Estimated Milestone Bundle Amount:** $1,039,018

**Year 4 Estimated Milestone Bundle Amount:** $1,124,364

**Year 5 Estimated Milestone Bundle Amount:** $1,082,497

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $4,220,390
Texana Center
Pass 3
Project Option 1.12.2 – Expand the Number of Community Based Settings where Behavioral Health Services may be Delivered in Underserved Areas: Enhance Service Availability of appropriate levels of behavioral health care (i.e., applied behavior analysis and speech-language pathology for children diagnosed with autism).

Unique RHP Project Identification Number: 081522701.1.4
Performing Provider Name/TPI: Texana Center / 081522701

Project Description: Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis, ABA, and speech-language pathology for children diagnosed with autism spectrum disorders, ASD) to expand the number of community based settings where behavioral health services may be delivered in underserved areas.

Provider Description: Texana Center is the Local Authority for Behavioral Healthcare and Intellectual Developmental Disabilities Services for 6 counties within the RHP 3 area: Austin, Colorado, Fort Bend, Matagorda, Waller and Wharton. Texana Center serves approximately 9,800 people annually (an estimated 7,000 in BH services and 3,000 in IDD services), employs 742, and has an annual operating budget of $39,211,988.

Intervention(s): This project will develop and implement evidence-based interventions of ABA and SLP in an additional location for children with an ASD diagnosis. Interventions include assessment, treatment development, and intervention overseen by Board Certified Behavior Analyst, BCBA, and Speech and Language Pathologist, SLP, as well as training care givers using ABA.

Need for the Project: There are increasing numbers of children diagnosed with ASD as evidenced by the latest statistics from the Center for Disease Control indicating 1:88 children have an ASD diagnosis. Texana Children’s Center for Autism only has 1 setting, currently serving 42 children; although a pass 1 project to serve 50 additional children has been proposed. This pass 3 project proposes to serve an additional 26 children. Waiting lists in the area can be as high as 200 per clinic and waits can be up to 2 years or until the child ages out of eligibility. Additionally, early intensive ABA can be costly, exceeding $50,000 per year. This project improves access to needed behavioral health services for low income families, 70-90% of children will be Medicaid eligible.

Target population: Children with ASD diagnoses or related conditions from age of diagnosis through the age of 8.

Category 1 expected patient benefits: Our goal is to increase utilization of community behavioral healthcare (i.e., ABA and SLP services for ASD). Capacity in DY1 was 42 at current site. Texana has proposed an 1115 Waiver project in pass 1 to serve 50 additional children. The goal of this pass 3 project is in DY3 to add 1 additional site. At the proposed third location, Texana would serve the following numbers of additional children beginning with 12 children DY3, 14 children DY 4, and at least 26 cumulative children by DY 5. A 24 month treatment cap will be imposed allowing for more children to be served by the 1115 waiver through DY5.

Category 3 Outcomes: The project seeks to increase the quality of life for individuals served. Specifically, these treatments are designed to demonstrate improvements in activities of daily living, increase functional skills, language/communication, social interactions, pre-academic achievement, as well as decrease problem behaviors as measured by an evidence-based and validated assessment tool for children diagnosed with ASD.

Project Valuation: By providing ABA services to children with autism, it allows for cost avoidance. The current project proposes to serve at least 26 unique children in years 3-5 with 25-40 hours per week per child of intensive applied behavior analysis intervention. Children will receive services approximately 6 hours per day, resulting in approximately 1,500 hours of treatment annually per child. Based on the figures derived from the 2007 Chasson study indicating savings of $208,500 per child with intensive ABA, the state of Texas could save $5,421,000 across 18 years of education by providing ABA treatment to these 26 children. This savings exceeds the total listed 5-year valuation for this project. Furthermore, based on the figures derived from the 1998 Jacobson study indicating $2,439,710 to $2,816,535 with inflation to age 55 per child served, the state of Texas could save $63,432,460 through age 55 for these 26 children by providing early intensive ABA treatment.
Project Option 1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders)

Unique RHP Project Identification Number: 081522701.1.4
Performing Provider Name/TPI: Texana Center / 081522701

Project Description:
This category 1 project, 1.12.2, will provide specialized behavioral health care services to the complex behavioral health population of children with diagnoses of autism spectrum disorders and related conditions.

Texana Children’s Center for Autism will add a third location to provide access to Applied Behavior Analysis (ABA) and Speech Language Pathology (SLP) interventions to serve 14 additional children at a time (from a current level of approximately 40 children at a time) as a 1115 Waiver pass 3 project. This will result in a minimum of 26 unique children to receive this type of service through year 5 in the pass 3 project. Texana previously proposed a pass 1 project of adding a second location to provide access to ABA and SLP interventions to serve 26 additional children at a time as a pass 1 project, resulting in a minimum of 50 additional children receiving services through year 5 in the pass 1 project. With adding both new locations from pass 1 and pass 3, Texana will be able to serve an additional 40 children at a time and 76 total cumulative unique children through all three sites, offering life changing intervention. Identified children with an autism diagnosis or related condition require 1:1 intensive services for 25-40 hours per week for at least 2 years. Treatment is most effective if initiated before the age of 4 but it is effective for all ages. The proposed age group includes age of diagnosis through age 8. Based on current waiting lists, between 70-90% of children served will be Medicaid eligible. Treatment will be provided in a clinic/day treatment, community, or home setting. Treatment will be limited to up to 24 months per child so that more children can benefit from the program.

The population of children with an autism diagnosis often has key health challenges and multiple issues such as lack of daily living skills, cognitive challenges, and limited support in the community. The State's mental health system provides some minimal services, but can only serve a fraction of the population. The existing behavioral healthcare environment does not provide the necessary range of specialized therapies needed to address the complex needs of a child with autism. Positive healthcare outcomes are contingent on the ability of the patients to obtain services as soon as possible after diagnosis. However, many Texas children are unable to access these much needed services.

There are increasing numbers of individuals diagnosed with Autism Spectrum Disorders (ASD). The latest statistics from the Center for Disease Control (CDC) indicate that 1 in 88 children have a diagnosis of autism. Repeated studies by special tasks forces and others such as the US Surgeon General and the National Autism Standards Project have consistently found that Applied Behavior Analysis (ABA) intervention is the most effective intervention for children with ASD. In fact, research indicates that approximately 50% of children that receive 1:1 intensive ABA before the age of 4 for 25-40 hours a week for at least 2 years will no longer meet the diagnostic criteria for an ASD diagnosis (Howard, et al. 2005). Recent research, including the National Standards Project, emphasizes the importance of empirically based Speech Language Pathology (SLP) intervention in addition to the primary mode of intervention of ABA.
With a success rate of 47 percent for early intensive behavioral intervention (Lovaas, 1987), one study found that cost savings following intensive ABA are estimated to be from $2,439,710 to $2,816,535 with inflation to age 55 per child served (Jacobson, Mulik, & Green, 1998).

This project proposes to enhance availability of specialized therapies, ABA and SLP treatment, for children with ASD consistent with best practices (Howard et al. 2005, National Autism Center’s National Standard’s Report 2009). The innovative care model proposed includes interventions to increase language and communication, social skills, play skills, group participation skills, self-help skills, pre-academics skills, natural environment training, feeding intervention, community skills, pre-vocational skills, school-readiness skills, and parent training. Treatment will be developed and supervised by Board Certified Behavior Analysts (BCBA) and licensed Speech and Language Pathologists. Treatment will be provided in a clinic/day treatment, community, or home setting. Eligible persons are individuals with ASD from the age of diagnosis through the age of 8.

**Major Project Activities, Goals, and Relationship to Regional Goals:**

The major project activity and goal is to provide applied behavior analysis (ABA) and speech language pathology intervention to children diagnosed with autism in underserved areas in order to address the regional goals of increased access to appropriate levels of healthcare, improved quality of care, and enhanced health of clients and families we serve. Research supports that the interventions outlined in this proposal will address these outcomes. Up to 50% of children with an autism diagnosis that receive 25-40 hours per week of intensive ABA beginning before the age of 4 for approximately 2 years achieve post treatment test scores in the normal/average range (Lovaas, 1987; Howard, et. al., 2005).

This project is consistent with several other regional goals. It contributes to development of a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the region, and improves health care outcomes. The project is consistent with the goal of developing a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes. It also increases access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, with more available locations regardless of their ability to pay. This is consistent with the regional goal of improving health for the population and lowering costs through these improvements. Research has shown that if we pay the costs of early intensive ABA as described upfront, the long-term savings far exceed initial costs. A 2007 study indicated that the state of Texas will save $208,500 per child across eighteen years of education with early intensive ABA (Chasson et al). Cost savings following intensive ABA are estimated to be $2,816,535 with inflation to age 55 per child served (Jacobson, Mulik, & Green, 1998).

**Starting Point/Baseline:**

The Texana Children’s Center for Autism currently only has 1 setting. In this setting, Texana currently serves 42 children diagnosed with Autism Spectrum Disorders or related conditions. Twenty of these children are able to access treatment via private funds or private insurance. The remaining twenty-two children are able to access services through an existing grant from the Department of Assistive and Rehabilitative Services, DARS. The Children’s

Regional Healthcare Partnership Plan
Region 3

669
Center for Autism anticipates serving approximately 50 total children by the end of this fiscal year (September 2012-August 31, 2012). These children receive between 15 and 32 hours of intensive ABA per week. Despite this, waiting lists in the area range from 30 to 200 per clinic and wait can be up to 2 years or until the child ages out of eligibility.

Texana Center submitted an 1115 Waiver pass 1 project to serve an additional 26 children at a time with intensive intervention 25-40 hours per week; with admission and discharges resulting in 50 children through DY5. With this pass 3 project Texana plans to expand to a third location in year 3. There will be only 1 additional site as part of pass 3 across the 5 years. This pass 3 project proposes serving an additional 14 children at a time with intensive intervention 25-40 hours per week; beginning with 12 children in DY 3, with admissions and discharges, serving at least 26 total unique children through DY5. Children will be limited to up to 24 months in the program in order to increase the absolute number of children served. See table below.

<table>
<thead>
<tr>
<th>Number of NEW Community-Based Sites where Children are Served (pass 3)</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cumulative Number of Children Served at NEW Community-Based Site (pass 3)</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Child Census at NEW Community-Based Site (pass 3)</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>Children Admitted to NEW Community-Based Site (pass 3)</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Children Discharged from NEW Community-Based Site (pass 3)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Projected Total Texana Children's Center census at any one time (3 sites: original, pass 1 and pass 3)</td>
<td>42</td>
<td>52</td>
<td>80</td>
<td>84</td>
<td>84</td>
</tr>
</tbody>
</table>

**Challenges and how to address:**

The proposed project faces challenges in more than one area. All anticipated challenges present with viable solutions. First, there is often a shortage of availability of licensed/certified therapists and other qualified staff in underserved areas. As the proposed project is an expansion of an established ABA program which has an association with the University of Houston Clear Lake, therapists can be trained while working in the established location and then moved to the underserved area.

Second, there is a lack of public awareness of available services. Initially, the proposed project will draw referrals from the local Early Childhood Intervention programs and the local Intellectual and Developmental Disabilities Authorities. The plan for public awareness will include information and education to local independent school districts, parent support groups, health/resource fairs, daycares, clinics, and pediatrician offices.

**5-Year Expected Outcome for Provider and Patients:**
The expected outcome for the proposed project is to expand services for children with an autism diagnosis to underserved areas. Families of children with an autism diagnosis would have available, economically accessible services to meet identified needs through the 1115 waiver program. Children faced with the challenge an autism diagnosis would be given the best possible opportunity to achieve significantly improved quality of life and school readiness skills. Children served will have increased trajectory of skills development and reduced need for special education services resulting in long term cost savings to the state for both special education and other behavioral healthcare services.

Rationale: Texana Center selected this project for the following reasons:

- This project is data driven. As previously mentioned, there are an increasing numbers of individuals diagnosed with Autism Spectrum Disorders (ASD). Current statistics from the CDC indicate that 1 in 88 children have a diagnosis of ASD. In fiscal year 2012, through Strategic Planning, Texana Center recognized the need to shift some resources from adult services to children services. Eighty-five percent of the individuals waiting for eligibility determination are under 21, and are seeking behavior supports and/or respite as a primary service. The 25 school districts in our local area reported that in the 2011-2012 school year, 4,332 students with IDD were served and 2,374 of these children had a diagnosis of ASD. As the number of children diagnosed with ASD increases, the need for treatment also increases. ABA and SLP are the treatments with the most evidence supporting their effectiveness (National Autism Center's National Standards Report, 2009). In 1999, the Surgeon General named ABA, the treatment of choice for children diagnosed with Autism. Lovaas (1987) documented 9/19 or 47% children who received early intensive (40 hr per week) ABA before the age of 4 for at least 2 years had cognitive and language scores in the normal range by age of 6-7 years. Numerous additional studies have supported this finding (e.g. Howard, et. al., 2005).

- This project addresses the needs of the community for expanded behavioral healthcare. RHP CN 2 - Insufficient access to behavioral health care services, resulting in lack of care or delay of care, delivery of inappropriate and insufficient care, unnecessary and preventable complications, and increased demand on criminal justice system. Children with ASD diagnoses in our area frequently never access services due to lack of funding or are placed on a waiting list for 1-3 years or until they age out of eligibility. This is highly detrimental to the trajectory of their future outcomes. Medicaid generally does not pay for this medically necessary treatment, and 70-90% of those served in this waiver program will be Medicaid eligible.

- This project is cost effective. In 1998, Jacobson et al found that cost savings following intensive ABA are estimated to be from $2,439,710 to $2,816,535 with inflation to age 55 per child served (Jacobson, Mulik, & Green, 1998). Additionally, in 2007, Chasson et al results indicate that the state of Texas will save $208,500 per child across eighteen years of education with early intensive ABA.

- Texana center has the experience to implement this project. Since 2004, Texana has been operating an intensive ABA program for children diagnosed with Autism, the Children’s Center for Autism. Texana has the administrative support and clinical expertise as well as the existing infrastructure to ensure a smooth and successful expansion.

Consistent with the DSRIP Category 1.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas, there are no required...
core project components listed in the menu. Core components from other areas that are included are: *Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population (children with an autism diagnosis).*

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

The Category 3 Quality Improvement Outcome Measure, IT-10.2 Quality of Life/Activities of Daily Living, relates to the Category 1.12.2 project of increased utilization of community behavioral healthcare services of ABA and SLP for individuals with ASD. These treatments are specifically designed to improve symptoms and function, two essential components of quality of life. Early intensive ABA treatment results in increased language and communication skills, improved social skills, achievement in pre-academic and academic areas, and decreased problem behaviors (Howard et al. 2005). Early intensive ABA as described above can be costly, exceeding $50,000 per year. This project will improve access to needed behavioral health services for low income families; 70-90% of these children will be Medicaid eligible.

Baseline data will be collected during years 2 and 3 using a variety of the below and related assessment tools. One or a combination of 2 or 3 of these tools will be utilized to demonstrate progress during years 3-5 based on baseline data collected during years 2 and 3.


- Demonstrated improvement in quality of life on the Assessment of Basic Language and Learning Skills (ABLLS-R), Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), and/or the Assessment of Functional Living Skills (FLS). Progress can be measured by examining changes in the student’s scores from one administration to the next (e.g., Goin-Kochel, Myers, Hendricks, Carr, &Wiley, 2007; Sullivan & Perry, 2006). The ABLLS-R and similar tools were selected because they are now commonly used by educators, school personnel, and psychologists to assess and monitor skills of children with autism who are receiving behavior therapy (e.g., Bradley-Johnson, Johnson, & Vladiescu, 2008; Goin-Kochel et al., 2007; Schwartz, Boulware, McBride, & Sandall, 2001) and, according to Aman et al. (2004), the ABLLS-R has been selected as an outcome measure by the National Institute of Mental Health Research Units in Pediatric Psychopharmacology and Psychological Intervention Autism Network.

**Relationship to other Projects:**

The development and improvement of services for patients with behavioral health disorders, such as ASD, is a focus of multiple projects throughout the RHP, including those in Category I for expanding access and Category II for developing innovative solutions to priority issues. This
project supports expanding specialty care capacity, developing behavioral health crisis stabilization as alternatives to hospitalization, providing an intervention for targeted behavioral health population to prevent unnecessary use of services in a specified setting, and recruiting, training, and supporting consumers of mental health services to provide peer support services. Texana has both a pass 1 and pass 3 projects addressing the behavioral health needs in under-served areas for children with an autism diagnosis. Texana also has pass 1 projects to address behavioral health crisis services and behavioral health crisis services for individuals with intellectual and developmental disabilities. In addition, Texana has a pass 2 project to improve access to specialty care for infants and toddlers as risk.

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

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from an inpatient unit. This initiative is similar to many others in the sense that it impacts the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs. Intellectual and developmental disabilities (IDD) are a large focus of our community including our local mental health authorities in the region. There are additional initiatives in the RHP plan with a focus on IDD and are represented in the addendum (Region 3 Initiative Grid). The IDD initiatives primarily support outcome measures of patient satisfaction scores, and admission/re-admission rates. Local Authorities for intellectual and developmental disabilities (IDD) services throughout the state are proposing the implementation of projects to improve access to services for individuals with IDD for their respective RHP areas. The Department of Aging and Disabilities Services (DADS) has encouraged local authorities to propose projects to address the needs of the IDD population including ASD. Specifically, Harris County MHMRA is proposing 2 projects that included ABA services, STARS and in-home services. The Andrews Center MHMRA is also proposing ABA services for children with autism.

**Plan for Learning Collaborative:**

Through this project, Texana Center and MHMRA of Harris County will expand the existing collaboration to include monthly telephone conferences to share best practices, new ideas and solutions for the autism intervention project. The established provider meetings will provide an effective forum for gathering input of stakeholders in the project processes. Through this expanded learning collaborative, Texana and participating Local Authorities will share challenges and testing of new ideas and solutions. Additionally, Texana plans to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System as appropriate. Texana’s participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. This exchange will facilitate effective processes, efficient use of resources, and consistent data benchmarking across similar projects statewide.

**Outcome Project Valuation:**
This project addresses a priority need for the population of individuals with ASD to receive intensive ABA and SLP services in the community. One of the goals of this project is to avert outcomes such as potentially avoidable inpatient admissions and readmissions in settings including general acute and psychiatric hospitals, state supported living centers, and self-contained special education classrooms; to promote wellness and adherence to treatment; to promote independence in the community; and to improve quality of life. The vision will be realized throughout the child's lifetime, however, the reduction in the need for self-contained special education classrooms and in some cases the elimination of the need for special education for children served in this project would be realized during the 4 year DSRIP project.

By providing ABA services to children with autism, it allows for cost avoidance. The current project proposes to serve at least 26 unique children in years 3-5 with 25-40 hours per week per child of intensive applied behavior analysis (ABA) intervention. At 6 hours per day, this will result in approximately 1,500 hours of treatment annually per child. Based on the figures derived from the 2007 Chasson study indicating savings of $208,500 per child with intensive ABA, the state of Texas could save $5,421,000 across 18 years of education by providing ABA treatment to these 26 children. These savings exceed the total listed 5-year valuation for this project. Furthermore, based on the figures derived from the 1998 Jacobson study indicating $2,439,710 to $2,816,535 cost savings with inflation to age 55 per child served, the state of Texas could save $63,432,460 through age 55 for these 26 children by providing early intensive ABA treatment.

**Total Five Year Valuation:** $4,449,821.

**Resources:**


<table>
<thead>
<tr>
<th>Texana Center</th>
<th>081522701</th>
<th>N/A</th>
<th>Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Milestone 1 [P-3]</strong>: Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for additional community based setting)</td>
<td><strong>Milestone 2 [P-8]</strong>: Participate in at least bi-weekly interactions (meeting, conference calls, or webinars) with other providers, and RHP to promote collaborative learning around shared or similar projects. Participation includes: 1) sharing challenges and any solutions; 2) sharing results and quantitative improvement that the provider is testing; and 3) identifying a new improvement and publically commit to test it in the week to come.</td>
<td><strong>Milestone 3 [P-8]</strong>: Participate in at least bi-weekly interactions (meeting, conference calls, or webinars) with other providers, and the RHP to promote collaborative learning around shared or similar projects. Participation includes: 1) sharing challenges and any solutions; 2) sharing results and quantitative improvement that the provider is testing; and 3) identifying a new improvement and publically commit to testing it in the week to come.</td>
<td><strong>Milestone 4 [P-8]</strong>: Participate in at least bi-weekly interactions (meeting, conference calls, or webinars) with other providers, and the RHP to promote collaborative learning around shared or similar projects. Participation includes: 1) sharing challenges and any solutions; 2) sharing results and quantitative improvement that the provider is testing; and 3) identifying a new improvement and publically commit to testing it in the week to come.</td>
</tr>
<tr>
<td><strong>Metric 1 [P-3.1]</strong>: Manual of operations for the project detailing administrative protocols and clinical guidelines. Baseline- existing protocols for the current setting. Goal- to modify/customize these protocols and create any necessary subsequent protocols for the additional setting. Data Source: Administrative protocols; clinical guidelines.</td>
<td><strong>Metric 1 [P-8.1]</strong>: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
<td><strong>Metric 1 [P-8.1]</strong>: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
<td><strong>Metric 1 [P-8.1]</strong>: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment <em>(maximum amount)</em>: $1,013,492</td>
<td><strong>Metric 2 [P-8.2]</strong>: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction.</td>
<td><strong>Metric 2 [P-8.2]</strong>: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction.</td>
<td><strong>Metric 2 [P-8.2]</strong>: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction.</td>
</tr>
</tbody>
</table>

**Regional Healthcare Partnership Plan**  
Region 3  
676
<table>
<thead>
<tr>
<th>081522701.1.4</th>
<th>1.12.2</th>
<th>N/A</th>
<th><strong>Enhance service availability of appropriate levels of behavioral health care</strong> <em>(applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Texana Center</td>
<td></td>
<td></td>
<td><strong>081522701</strong></td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s):</strong></td>
<td><strong>081522701.3.5</strong></td>
<td><strong>IT-10.2</strong></td>
</tr>
<tr>
<td><strong>Quality of Life/Functional Status/ ADL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
</tr>
<tr>
<td></td>
<td>interaction, with at least quarterly summary.</td>
<td>progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary.</td>
<td>progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary.</td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 2</strong> Estimated Incentive Payment: $364,344</td>
<td><strong>Milestone 5</strong> Estimated Incentive Payment: $ 597,220</td>
<td><strong>Milestone 7</strong> Estimated Incentive Payment: $574,431</td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 3</strong>[P-6]: Establish behavioral health services in new community-based settings in underserved areas</td>
<td><strong>Milestone 6</strong> [I-11]: Increased utilization of community behavioral healthcare (i.e., ABA and SLP services for autism).</td>
<td><strong>Milestone 8</strong> [I-11]: Increased utilization of community behavioral healthcare (i.e., ABA and SLP services for autism).</td>
</tr>
<tr>
<td></td>
<td>Metric 2[P-6.1]: Number of new community based settings where behavioral health services are delivered (i.e. applied behavior analysis and speech and language pathology) Baseline/Goal: 2 settings (original and pass 1) Goal: add 1 additional setting to total 3 settings Data source: Project Documentation</td>
<td>Metric 1 [I-11.1]: Percent utilization of new community behavioral healthcare services. Baseline: 12 children in DY 3 Goal: 14 cumulative children served will be funded by the expansion including DY 3-4 Data Source: Claims data and encounter data</td>
<td>Metric 1 [I-11.1]: Percent utilization of new community behavioral healthcare services. Baseline: 14 cumulative children based on DY 4 Goal: 26 cumulative children served will be funded by the expansion including DY 3-5 Data Source: Claims data and encounter data</td>
</tr>
<tr>
<td></td>
<td>Milestone 3 Estimated Incentive Payment <em>(maximum amount):</em> $364,343</td>
<td>Milestone 6 Estimated Incentive Payment: $ 597,219</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 4</strong> [I-11]: Increased utilization of community behavioral healthcare (i.e., ABA and SLP services for autism).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texana Center</td>
<td>081522701</td>
<td>N/A</td>
<td>Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders)</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>081522701.3.5</td>
<td>IT-10.2</td>
<td>Quality of Life/Functional Status/ ADL</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [I-11.1]: Percent utilization of new community behavioral healthcare services. Baseline: 0 children at new setting Goal: 12 children served will be funded by the expansion Data Source: Claims data and encounter data</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment: $364,343</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $1,013,491</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 3 Estimated Milestone Bundle Amount: $1,093,030</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 Estimated Milestone Bundle Amount: $1,194,439</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5 Estimated Milestone Bundle Amount: $1,148,861</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5): $4,449,821*
Texas Children's Hospital
Pass 1
Project Option 1.9.2- Expand Access to Specialty Care

**Unique RHP Project ID:** 1391351091.1  
**Performing Provider Name/TPI:** Texas Children’s Hospital/ 139135109.1.1

**Project Summary:**
This project will increase capacity in our Neurology Clinic at Texas Children’s Hospital. Referrals into the TCH pediatric neurology clinic increased significantly from a monthly average of 600 in 2010 to a monthly average of 760 in 2012. The focus of this project is to equip the clinical service with the resources needed to address the significant patient care need for pediatric neurological services in the area.

**Provider:**
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765</td>
<td>Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%</td>
<td>Hispanic- African American- Caucasian- Asian- Other- American Indian-</td>
</tr>
</tbody>
</table>

**Intervention(s):**
The Neurology Service will focus on provider productivity and hire additional clinical providers in order to expand internal capacity. Current scheduling processes will be reviewed to increase the availability of providers to increase volumes, and the service will evaluate increasing services at the five additional community locations to increase the volume of patients seen through pediatric neurology clinics across the Houston area.

**Need for the project:**
Pediatric neurology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012).

**Target Population:**
The areas of clinical focus include multiple sclerosis, muscular dystrophy, Rhett syndrome, cerebral palsy, epilepsy, seizure disorders, headaches, movement disorders, neurogenetics, pediatric stroke, and peripheral nerve disorders or injuries.

**Category 1 or 2 expected patient benefits:**
Our DY3 goal is to improve upon DY2 baseline of patient volume by 2.5% or 500 additional visits compared to baseline. Our DY4 goal is for 5% increase of patient visits or 1,002 additional visits compared to baseline. Our DY5 goal is for 7.5% increase of patient visits or 1,502 additional visits compared to baseline.

Category 3 outcomes:
IT-5.1 Improve Cost of Care
IT 5.2: Per Episode Cost of Care
IT 5.3: Other Outcome Improvement Target: Reduced Length of Stay
IT-1.1: Third Next Available Appointment
Project Option-1.9.2 Expand Access to Specialty Care: Expand Pediatric Neurology

**Unique Project ID:** 139135109.1.1  
**Performing Provider Name/ TPI:** Texas Children’s Hospital/139135109

**Project Description**

*Texas Children’s Hospital proposes to increase capacity for care in Pediatric Neurology Clinic.*

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Specifically this project will increase capacity in our Neurology Clinic. Pediatric neurology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). Referrals into the TCH pediatric neurology clinic increased significantly from a monthly average of 600 in 2010 to a monthly average of 760 in 2012. The focus of this project is to equip the clinical service with the resources needed to address the significant patient care need for pediatric neurological services in the area.

The Neurology Service at TCH offers a wide range of clinical services for pediatric neurologic conditions in six locations across the Houston metropolitan area. In addition to general needs related to pediatric neurology, areas of clinical focus include multiple sclerosis, muscular dystrophy, Rhett syndrome, cerebral palsy, epilepsy, seizure disorders, headaches, movement disorders, neurogenetics, pediatric stroke, and peripheral nerve disorders or injuries. The Neuroscience programs at TCH provide outstanding multidisciplinary programs in clinical child neurology training and basic science research training. Areas of clinical training include pediatric neurology, neurodevelopmental pediatrics and behavioral pediatrics. Basic science programs focus upon the genetic and molecular basis of neurodevelopmental disorders and brain development. Training fellows benefit from close interaction with faculty, state of the art facilities and diverse patient populations. The division is committed to nurturing the careers of individuals entering these training programs.

Neuroscience sponsors innovative clinical and basic science research into the underlying causes of childhood neurological and developmental disorders. A wide array of clinical research is underway to improve the understanding and treatment of several neurological conditions, including epilepsy, autism, muscular dystrophy, headaches, pediatric stroke, and sleep disorders. Basic science research is being conducted in the Cain Foundation Laboratories into the underlying mechanisms of brain development and the genesis of early life seizures and epilepsy.
Researchers at the Jan and Dan Duncan Neurological Research Institute at Texas Children's are now working on new breakthroughs in the treatment of childhood neurological diseases.

**Goals and Relationship to Regional Goals:**

**Project Goals:** To meet the growing demand for specialized pediatric services TCH will:

- Focus on provider productivity to optimize clinical time for all providers
- Establish an initiative to review scheduling processes to increase the availability of these targeted providers
- Expand internal capacity by hiring additional clinical providers
- Enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve and increase hours at the five additional community locations for specialty care.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients’ needs throughout the entire region, and improves health care outcomes and patient satisfaction

**Challenges:**

In Texas, limited Medicaid reimbursement is an ongoing challenge for children’s hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children’s health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded. While we continue to increase our overall volumes at all of our locations by an average of about 13% in the last 3 years, the service struggles to keep up with increased demand given that Neurology serves patients locally, statewide, across the nation and internationally. By reconfiguring clinic processes, scheduling and the addition of more providers, we will try to improve this measure. Ultimately, the overall success of this project is dependent upon the compliance rate of our patients and primary caretakers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care and improved access.

**Five year expected outcome for provider and patients:**

Texas Children’s Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Pediatric neurology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). Referrals into the TCH pediatric neurology clinic increased significantly from a monthly average of 600 in 2010 to a
monthly average of 760 in 2012. Given the high demand and provider shortage, for the majority of FY10 and FY11, access to neurological services remains a challenge.

**Starting Point/Baseline:** The baseline of patient volumes for FY 12 is 20,031 across all service locations. Our fiscal year is from October 1\(^{st}\) to September 30\(^{th}\).

**Rationale:**
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH’s existing neurology services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. The Neurology service line at TCH has consistently ranked in the top ten programs nationally in US News and World Report, with a ranking of 5\(^{th}\) in its latest report. Specifically, this service will provide comprehensive care for children within focused specialty programs across six locations of care including: multiple sclerosis, muscular dystrophy, Rhett syndrome, cerebral palsy, epilepsy, seizure disorders, headaches, movement disorders, neurogenetics, pediatric stroke, and peripheral nerve disorders or injuries.

Our project significantly enhances TCH’s existing neurology services. Region 3 RHP summit identified inadequate number of specialty providers as an area of community need (CN.2). This project aims to tackle this issue from multiple angles. The service plans to recruit nationally for these highly specialized clinicians. The strong clinical, research, and academic programs within TCH and Baylor College of Medicine provides an advantage for recruitment of these experts. Additionally, the service will look within its own clinical service lines to examine the activity levels of the providers and look to more efficiently utilize clinician schedules so as to increase access to patient care. The service will also examine roles and responsibilities of physician and clinical support to ensure that individuals are working as efficiently as possible within the scope of their license so that clinical time can be focused on providing additional clinical services to patients.

**Project Components:**
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

a. Conduct specialty care gap assessment based on community need for subspecialty.
   b. Implement transparent standardized referrals across the system
   c. Increase specialty care volume of visits and evidence of improved access for patients seeking services
   d. Increase service availability hours and increase number of specialty clinic locations.
   e. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care
provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.¹

**Milestones and Metrics**
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-21 (P-21.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

**Unique community need identification number the project addresses:** CN.2: Inadequate access to specialty care, CN.6: Inadequate access to treatment and services designed for children.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This project will allow Texas Children’s to significantly enhance our existing Neurology appointment availability. The providers working within the Neurology service at TCH are experts in their field. Part of the reason for increased referrals and the need for greater access stems from the fact that children statewide, nationally, and internationally would like access to the professionals working at TCH and specifically in the area of neurology. Adding to the pool of expert clinicians, as well as working within the current service lines to identify how current providers can expand their clinical practices will greatly enhance the services currently offered to our patients by not only reaching more children, but also enhancing the types of clinical services we can offer those children.

**Related Category 3 Outcome Measure(s):**
OD-5 Cost of Care
IT-5.1 Improved Cost Savings
IT-5.2 Per episode cost of care
IT-5.3 Length of stay

OD-1 Primary Care and Chronic Disease Management
IT-1.1: Third Next Available Appointment

**Reasons/rationale for selecting the outcome measures:**
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care services and subsequent costs.² Because of the continued growth in demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The Affordable Care Act focused on the triple aim-

---

improving quality, reducing costs and improving access. This project strives to meet those same
goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Relationship to other Projects:** All of Texas Children’s projects are working to expand access
to subspecialty care for the pediatric population. Texas continues to have a growing pediatric
population and a shortage of specialized pediatric providers.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of
healthcare in future years so it is critical that they receive the access needed throughout their
pediatric lives. The focus of pediatric specialty care is similar throughout the region with a
concentrated focus in the Harris county proper geographic region and allows for the expansion of
access to numerous specialties such as cardiology, neurology, ENT, and many more. The
outcome measures focus to appropriate length of stay, per episode cost of care, and improved
cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our
region. (addendum)

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

**Project Valuation:** This project’s value is based on the benefits related to cost avoidance of
medical expenses and improved quality of life. For example, increased provider capacity leads to
reduction in emergency room visits and reduction in inpatient hospital visits.\(^3\) Our valuation also
includes an increase in the patient’s quality of life. We are using a conservative Quality
Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric
population.\(^4\) The QALY is used as a one-time improvement in the quality of life, even though
we know the patient’s quality of life will be improved for many years. We recognize that this is a
government funded waiver and thus we chose to have conservative valuations out of respect for
the taxpayer funded program. We have academic literature citing the link between access to
appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and
emergency room.\(^3\)

---

\(^3\) Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does

**Regional Healthcare Partnership Plan**

### EXPAND ACCESS TO SPECIALTY CARE: EXPAND PEDIATRIC NEUROLOGY

<table>
<thead>
<tr>
<th>Related Category</th>
<th>Outcome Measure(s):</th>
<th>Texas Children’s Hospital</th>
<th>139135109</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1</strong></td>
<td><strong>Metric 1 (I-23)</strong></td>
<td><strong>Improved Cost Savings</strong></td>
<td><strong>Per episode cost of care</strong></td>
</tr>
<tr>
<td><strong>Outcome Measure(s):</strong></td>
<td><strong>IT- 5.1</strong></td>
<td><strong>Length of stay</strong></td>
<td><strong>A-D</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
</tbody>
</table>

**Milestone 1 (P-1):** Conduct specialty care gap assessment to determine barriers to accessing subspecialty care. Develop plan and identify key initiatives for changes in provider schedules in DY3.

**Metric 1 P-1.1** Documentation of gap assessment
Data Source: Gap Assessment

**Milestone 1 Estimated Incentive Payment:** $1,074,322

**Milestone 2 (P-21):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

**Metric 1 [P-21.1]:** Participate in semi-annual face-to-face meetings or

**Milestone 3 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 (I-23.1):** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12).

- Total number of visits for reporting period
- Data Source: EPIC Medical Record

**Goal:** Increase specialty care clinic volume of visits by 2.5% of baseline, or 500 additional visits compared to baseline, and evidence of improved access for patients seeking services.

**Milestone 3 Estimated Incentive Payment:** $1,172,082.50

**Milestone 4 (P-21):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance).

**Milestone 4 Estimated Incentive Payment:** $1,175,489

**Milestone 5 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 (I-23.1):** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12).

- Total number of visits for reporting period
- Data Source: EPIC Medical Record

**Goal:** Increase specialty care clinic volume of visits by 5% of baseline, or 1,002 additional visits compared to baseline, and evidence of improved access for patients seeking services.

**Milestone 5 Estimated Incentive Payment:** $971,056.50

**Milestone 6 (P-21):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance).
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>139135109.1.1</th>
<th>1.9.2</th>
<th>A-D</th>
<th>EXPAND ACCESS TO SPECIALTY CARE: EXPAND PEDIATRIC NEUROLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>139135109.3.1</td>
<td>IT-5.1</td>
<td></td>
<td>139135109.139135109.3.2 IT-5.2</td>
</tr>
<tr>
<td></td>
<td>139135109.3.3</td>
<td>IT-5.3</td>
<td></td>
<td>139135109.3.44 IT-1.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2** (10/1/2012 – 9/30/2013)

- seminars organized by the RHP.
- Goal: Participate in all semi-annual face-to-face meetings or seminars.
- Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

**Milestone 2 Estimated Incentive Payment:** $1,074,322

Each participating provider should publicly commit to implementing these improvements.

Metric 4 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.
- Goal: Participate in all semi-annual face-to-face meetings or seminars.
- Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

**Milestone 4 Estimated Incentive Payment:** $1,172,082.50

providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.
- Goal: Participate in all semi-annual face-to-face meetings or seminars.
- Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

**Milestone 6 Estimated Incentive Payment:** $1,175,489

Year 3 (10/1/2013 – 9/30/2014)

Year 3 Estimated Milestone Bundle Amount: $2,344,165

Year 4 (10/1/2014 – 9/30/2015)

Year 4 Estimated Milestone Bundle Amount: $2,350,979

Year 5 (10/1/2015 – 9/30/2016)

Year 5 Estimated Milestone Bundle Amount: $1,942,113

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $8,786,001
Project Option 1.9.2- Expand Access to Specialty Care

**Unique RHP Project ID:** 139135109.1.2  
**Performing Provider Name/TPI:** Texas Children’s Hospital/ 139135109

**Project Summary:** This project will increase capacity in our Cancer and Hematology Clinic as the demand for health care services grows in the state of Texas. It will fulfill our tri-part mission of providing quality pediatric care, training the next generation of pediatric providers and investigating ways to improve care through innovative therapies specific to Sickle Cell Disease.

**Provider:**  
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765</td>
<td>Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%</td>
<td>Hispanic-  African American- Caucasian- Asian- Other- American Indian-</td>
</tr>
</tbody>
</table>

**Intervention(s):**  
This project will increase capacity in our Cancer and Hematology Clinic as the demand for health care services grows in the state of Texas. It will fulfill our tri-part mission of providing quality pediatric care, training the next generation of pediatric providers and investigating ways to improve care through innovative therapies specific to Sickle Cell Disease.

**Need for the project:**  
The pediatric population continues to grow in Texas resulting in an increase in demand of health care services for the treatment of rare blood and tissue disorders. The demand for services for Sickle Cell patients continues to increase due to the growing African American and Hispanic populations. Additionally, Pediatric hematologists and oncologists have been identified as a subspecialty facing a workforce shortage.

**Target Population:**  
All patients diagnosed with Sickle Cell Disease within the Texas Children’s Cancer and Hematology Service line.

**Category 1 or 2 expected patient benefits:**  
DY3 goal is to reduce overall cycle time for office visit appointments by 15% from baseline of 150 minutes. Our goal is to increase the number of visits by 3% in DY4 or 120 visits, and by 6% in DY5 compared to baseline established in DY2 or 240 visits.
Category 3 outcomes:
OD-5 Cost of Care
IT- 5 Improving Cost of Care
IT 5.2: Per Episode Cost of Care
IT 5.3: Other Outcome Improvement Target: Reduced Length of Stay
OD1-Chronic Disease Management
IT-1.1: Third Next Available Appointment
Project Option- 1.9.2 Expand Access to Specialty Care: Pediatric Hematology/Cancer

Unique Project ID: 139135109.1.2
Performing Provider Name/TPI: Texas Children’s Hospital/ 139135109

Project Description:

*Increase access to care by providing comprehensive, integrated, multidisciplinary and family-centered care to children with non-malignant blood disorders.*

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Specifically, this project will increase capacity in our Cancer and Hematology Clinic. Funding for this project will allow Texas Children’s to fulfill our tri-part mission of providing quality pediatric care, training the next generation of pediatric providers and investigating ways to improve care through innovative therapies. Texas Children’s Cancer and Hematology Center is ranked # 4 in the *2012 U.S. News and World Report Best Children’s Hospitals* and is the only pediatric cancer center in Texas ranked in the top 10. As the pediatric population continues to grow in Texas, so does the demand for health care services, especially, programs that treat rare blood and tissue disorders. Pediatric hematologists and oncologists are identified as subspecialty facing a workforce shortage and their profession’s growth lags consumer demand both at the national and state levels (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). This is a high Medicaid population, currently our cancer clinic is 70% Medicaid. The Cancer and Hematology Center aspires to provide comprehensive, integrated, multidisciplinary and family-centered care to children with non-malignant blood disorders. This center is the largest hematology-oncology service line in the nation and the only Sickle Cell Center in the Harris County area. Specifically, the Hematology Center offers a state-of-the-art, team-based program which will provide comprehensive care for children within focused specialty programs including:

- Hemoglobinopathies (sickle cell disease and thalassemias)
- Hemostasis and Thrombosis Disorders (HAT) (bleeding and clotting disorders)
- Bone Marrow Failure Syndromes
- General Disorders of red blood cells, Platelets, and Neutrophils
- Conduct clinical and basic science research to seek to develop new knowledge and treatment options that lead to a cure
- Train future leaders in areas of non-malignant blood disorders.
The integrated approach includes the development and implementation of a series of clinical practice guidelines to ensure patients receive the best possible care. One of the areas of focus will be the treatment and management of Sickle Cell Disease. Currently there are an estimated 7,000 people in the state of Texas with this disease. For children afflicted with this disease, Texas Children’s Sickle Cell Center is the only comprehensive Sickle Cell Center in the region. The shortage of hematologists that can provide care to both adolescents and young adults is already creating major problems for the transition of these patients into adult life. Demand for services for sickle cell patients continues to increase due to the growing African American and Hispanic populations. In addition, recent data demonstrates that increased patient encounters improves patient compliance and better management of the disease - thus decreases mortality and morbidity, while preserving productivity.

Goals and Relationship to Regional Goals:

Project Goals: To meet the growing demand for acute pediatric hematology/oncology services, TCH will:

- Focus on provider productivity to optimize clinical time for all providers and enhance training of subspecialists and fellows, including the training of dual board certified physicians (adult and pediatric hematology and/or oncology)
- Establish an initiative to review scheduling processes to increase the appointment availability of these targeted providers that aligns with new clinic capacity,
- Expand provider capacity by hiring additional clinicians and support staff,
- Expand service availability through the designing and building of a Comprehensive Hematology Center at Texas Children’s Hospital.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients’ needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges: There is an acute shortage of hematologists and oncologists who can provide care to our older adolescents and young adults. Recent data from the American Society of Clinical Oncology’s Workforce Study published in 2007 has shown that by the year 2020 there will be a shortage of between 2,350 and 3,800 oncologists, a problem that will be magnified by a 48% increase in the overall demand for oncology visits. Since physicians trained in adult hematology also see patients with “malignant” hematological disorders (such as leukemias), there will be few hematologists that will have the capacity to see “benign” hematological disorders, such as sickle cell disease. Due to the aging of the population and the associated increase in the prevalence of cancers in the elderly population will drastically limit the availability of trained oncologists to take care of young adults with cancer. Furthermore, many young adults have better treatment outcomes when treated according to pediatric protocols. There is thus a growing need to train
physicians in both pediatrics and medicine (med/peds) who then also can specialize in taking care of adolescents and young adults (up to 25 years of age) with cancer or blood disorders. In Texas, limited Medicaid reimbursement is an ongoing challenge for children’s hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children’s health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded.

**Five year expected outcome for provider and patients:**
Texas Children’s Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

**Starting Point/Baseline:** The baseline of patients in FY 2012 is 4,000. Our fiscal year runs from October 1st to September 30th. The baseline for patient cycle time is 150 minutes.

**Rationale:**
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH’s existing pediatric cancer and hematology services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. In order to increase access The Cancer and Hematology Center aspires to provide comprehensive, integrated, multidisciplinary and family-centered care to children with non-malignant blood disorders. The center is renowned for its research and therapies for blood disorders. This center employs faculty who are extensively published and who are sought after for national conference speaking opportunities to educate the medical community at large of hematologic/oncologic disorders. Specifically, the hematology faculty presented locally, nationally and internationally 53 oral presentations, authored 25 manuscripts and/or book chapters and led 2 national symposiums on the care of hematology patients.

Specifically, the Hematology Center will provide comprehensive care for children within focused specialty programs including:

- Hemoglobinopathies (sickle cell disease and thalassemias)
- Hemostasis and Thrombosis Disorders (HAT) (bleeding and clotting disorders)
- Bone Marrow Failure Syndromes
- General Disorders of red blood cells, Platelets, and Neutrophils
- Conduct clinical and basic science research to develop new knowledge and treatment options that lead to a cure
- Train future leaders in areas of non-malignant blood disorders.

**Project Components:**
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

a. Conduct specialty care gap assessment based on community need for subspecialty.
b. Implement transparent standardized referrals across the system
c. Increase specialty care volume of visits and evidence of improved access for patients seeking services

d. Increase service availability hours and increase number of specialty clinic locations.

e. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges. It is our goal to reach the industry standard of less than 14 days for the 3rd available appointment.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.¹

The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

Customizable Improvement Milestone and Metric was chosen in order to specifically tailor the intent of project to the targeted pediatric population.

- Unique community need identification number the project addresses: CN.2: Inadequate access to specialty care., CN.6: Inadequate access to treatment and services designed for children.

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

Our initiative will increase our capacity to see a growing population of children, adolescents and young adults with blood disorders or cancer through increased efficiencies. The expanded program will not only provide services to larger population of children in need but will also provide much needed services for the vulnerable population of older adolescents and young adults by increasing the age range of patients served from 21 to 25 years. The program will help train a future generation of pediatric hematologists/oncologists that can provide care to a large segment of the population of Harris County with blood disorders or cancer.

Related Category 3 Outcome Measure(s):

OD-5 Cost of Care
IT 5.1: Improved Cost Savings
IT 5.2: Per Episode of Care
IT 5.3: Other Outcome Improvement Target

Reasons/rationale for selecting the outcome measures:

Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children, adolescents and young adults and reduction in unnecessary health care costs.² We recognize that while increasing access to care we need to

---

continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Relationship to other Projects:** All of Texas Children’s projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

This project will compliment other projects designed to improve appropriate access to specialty care, improve chronic care management, facilitate transition to adulthood and those designed to improve the patient experience.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

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

**Project Valuation:** This project’s value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation also includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.

---


### Related Category 3

**Outcome Measure(s):**
- 139135109.1.2
- 139135109.3.4
- 139135109.3.5
- 139135109.3.6
- 139135109.3.45

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

### Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care

**Metric 1 P-1.1 Documentation of gap assessment**
- **Data Source:** Gap Assessment
- **Milestone 1 Estimated Incentive Payment:** $658,403.50

### Milestone 2 (P-8) (P-21): Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

**Metric 1 [P 21.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.
- **Goal:** Participate in all semi-annual face-to-face meetings or seminars.

<table>
<thead>
<tr>
<th>IT- 5.1</th>
<th>IT- 5.2</th>
<th>IT- 5.3</th>
<th>IT- 1.1</th>
</tr>
</thead>
</table>

### Milestone 3 (P-17): Implement the re-design of Texas Children’s Hematology Clinic to increase operational efficiency, shorten patient cycle time and increase provider productivity.

**Metric 1 (P-17.1):** Number of medical specialty clinics that have completed clinic redesign.
- **Numerator:** Average cycle time of appointments in hematology clinic that has undergone re-design.
- **Denominator:** Overall average cycle time of appointments in the Cancer and Hematology Clinic.
- **Data Source:** Specialty clinic appointment tracking system (EPIC)
- **Goal:** Reduce cycle time by 15% from baseline of 150 minutes.

**Milestone 3 Estimated Incentive Payment:** $718,283

### Milestone 5 (I-23): Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 (I-23.1):** Documentation of improved number of visits.
- **Demonstrate improvement over prior reporting period (baseline established in FY12).**
  - **Numerator:** Total number of visits for reporting period.
  - **Denominator:** Data Source: Registry, EHR
  - **Goal:** Increase patient visits by 3% (120 visits) over baseline.

**Milestone 5 Estimated Incentive Payment:** $720,371.50

**Milestone 7 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.
- **Metric 1 (I-23.1):** Documentation of increased number of visits.
- **Demonstrate improvement over prior reporting period (baseline established in FY12).**
  - **Numerator:** Total number of visits for reporting period.
  - **Denominator:** Data Source: Registry, EHR
  - **Goal:** Increase patient visits by 6% (240 visits) over baseline.

**Milestone 7 Estimated Incentive Payment:** $595,089.00

### Milestone 6 (P-21): Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to

**Milestone 8 (P-21):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>139135109.3.4</th>
<th>139135109.3.5</th>
<th>139135109.3.6</th>
<th>139135109.3.45</th>
<th>Expand Access to Specialty Care: Pediatric Hematology/Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Children’s Hospital</td>
<td>IT-5.1</td>
<td>IT-5.2</td>
<td>IT-5.3</td>
<td>IT-1.1</td>
<td></td>
</tr>
<tr>
<td>Improved Cost Savings</td>
<td>Per Episode of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Outcome Improvement Target</td>
<td>Third Next Available Appointment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2** (10/1/2012 – 9/30/2013)

- Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.
- Milestone 2 Estimated Incentive Payment: $658,403.50

**Year 3** (10/1/2013 – 9/30/2014)

- Meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.
- Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.
- Milestone 4 Estimated Incentive Payment: $718,283

**Year 4** (10/1/2014 – 9/30/2015)

- Implementing these improvements.
- Metric 1 [P-21]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.
- Milestone 6 Estimated Incentive Payment: $720,371.50

**Year 5** (10/1/2015 – 9/30/2016)

- Publicly commit to implementing these improvements.
- Metric 1[P-21]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.
- Milestone 8 Estimated Incentive Payment: $595,089.00

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $1,316,807

**Year 3 Estimated Milestone Bundle Amount:** $1,436,566

**Year 4 Estimated Milestone Bundle Amount:** $1,440,743

**Year 5 Estimated Milestone Bundle Amount:** $1,190,178

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $5,384,294
Project Option 1.9.2- Expand Access to Specialty Care

**Unique RHP Project ID:** 139135109.1.3  
**Performing Provider Name/TPI:** Texas Children’s Hospital/ 139135109

**Project Summary:** Increase critical access for the Harris County and surrounding communities to care for pediatric patients with diseases characterized by inflammation of the joints, muscles, and/or tendons.

**Provider:**
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation’s largest general pediatrician group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966</td>
<td>Medicaid and CHIP- 53.6%</td>
<td></td>
</tr>
<tr>
<td>Births (babies delivered)-</td>
<td>Commercial Insurance- 40.6%</td>
<td></td>
</tr>
<tr>
<td>2,181</td>
<td>Self-Pay- 1.8%</td>
<td></td>
</tr>
<tr>
<td>Emergency visits-113,586</td>
<td>Medicare- 1.2%</td>
<td></td>
</tr>
<tr>
<td>Outpatient visits-</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Intervention(s): | Increase critical access for the Harris County and surrounding communities to care for pediatric patients with diseases characterized by inflammation of the joints, muscles, and/or tendons. |

**Need for the project:**
Pediatric Rheumatology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012).

**Target Population:**
In addition to general pediatric rheumatologic needs, there is a substantial need for increased access for pediatric patients that suffer from multiple forms of high risk Lupus and those requiring semi-urgent/urgent outpatient care.

**Category 1 or 2 expected patient benefits:**
I-23.1: Our goal is to increase the number of visits by 5% in DY3 or 83 additional visits compared to baseline, by 10% in DY4 or 165 additional visits compared to baseline, and by 15% in DY5 or 248 additional visits compared to baseline.

**Category 3 outcomes:**
OD 5 – Cost of Care
IT-5.1 Improve Cost of Care
IT 5.2: Per Episode Cost of Care
IT 5.3: Other Outcome Improvement Target: Reduced Length of Stay
IT-1.1: Third Next Available Appointment
Project Options-1.9.2 Expand Specialty Access: Pediatric Rheumatology Care

**Unique Project ID:** 139135109.1.3

**Performing Provider Name and TPI:** Texas Children’s Hospital/ 139135109

**Project Description:**
*Texas Children’s Hospital proposes to increase capacity, improve care and reduce appointment wait time in our Rheumatology Clinic.*

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Our project proposal will significantly improve access to pediatric subspecialty care. Specifically this project will increase capacity in our Rheumatology Clinic. Pediatric Rheumatology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). Our clinic provides critical access for the Harris County and surrounding communities to care for pediatric patients with diseases characterized by inflammation of the joints, muscles, and/or tendons. Referrals into the TCH pediatric rheumatology clinic increased significantly from a monthly average of 60 in 2010 to a monthly average of 125 in 2012.

There are two specific areas where we intend to focus the expansion of our access to care. First, there is a substantial need for increased access for pediatric patients that suffer from multiple forms of high risk Lupus in our community. In addition, there is a need to expand access for a semi-urgent/urgent clinic, which will divert them from presenting unnecessarily in our Emergency Center. Part of the task of the urgent/semi-urgent clinic would also include community physician education for rheumatologic diseases. The intention of the education would be to provide the physicians with a comprehensive understanding of initial treatment for possible rheumatology diagnosis and when referrals should be initiated. Education sessions would include exclusive visits to those practices in the west and south side of Houston (these areas account for 80% of the referrals to our service).

**Goals and Relationship to Regional Goals:**

**Project Goals:** To meet the growing demand for specialized pediatric services TCH will:

1. Focus on provider productivity to optimize clinical time for all providers
2. Establish an initiative to review scheduling processes to increase the availability of these targeted providers
3. Expand internal capacity by hiring additional clinical providers
4. Enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve 1-3 additional community locations for rheumatology care
5. Provide education to community providers
6. Enhance training of subspecialists and fellows
7. Decrease unnecessary Emergency Center visits

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients’ needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges:
There are less than 300 active pediatric rheumatologists in the country and many of the providers are approaching retirement (The Rheumatologist, July 2012- “Pediatric Rheumatologist Increasing in Number but still Rare”). In Texas, limited Medicaid reimbursement is an ongoing challenge for children’s hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children’s health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded. There are currently only 20 active pediatric rheumatology fellowship programs in the United States, which train and graduate a maximum of 15 board-eligible, fellowship-trained pediatric rheumatologists each year.

Five year expected outcome for provider and patients:
The baseline of patient volumes in FY 12 is 1650. Our fiscal year runs from October 1st through September 30th.

Rationale:
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH’s existing pediatric rheumatology services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. Specifically,
we will provide comprehensive care for children within focused specialty programs including: diseases characterized by inflammation of the joints, muscles, and/or tendons, including high risk Lupus and Juvenile Rheumatoid Arthritis.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home. Increasing pediatric population and continued lack of pediatric subspecialists due to the inequity in reimbursement between Medicaid and Medicare is an ongoing problem for children’s hospitals and the pediatric health care workforce. Our project significantly enhances TCH’s existing developmental pediatric services. Region 3 RHP summit identified inadequate number of specialty providers as an area of community need (CN.2).

**Project Components:**
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

a. Conduct specialty care gap assessment based on community need for subspecialty.
b. Implement transparent standardized referrals across the system
c. Increase specialty care volume of visits and evidence of improved access for patients seeking services
d. Increase the number of specialty clinic locations
e. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges.

**Milestones and Metrics**
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-21 (P-21.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This project will enhance current services by expanding and maximizing provider accessibility that will result in a greater number of patients served. In addition it will result in prompt service and allow more children access to rheumatology subspecialty care.

**Related Category 3 Outcome Measure(s):**
OD-5: Cost of Care
IT-5.1: Improved cost savings
IT-5.2: Per Episode Cost of Care
IT-5.3: Length of Stay

OD-1 Primary Care and Chronic Disease Management

---

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs. Because of the continued growth in demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The Affordable Care Act focused on the triple aim – improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Relationship to other Projects:
All of Texas Children’s projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Relationship to Other Performing Providers’ Projects and Plan for Learning Collaboratives:
This project will compliment other projects designed to improve appropriate access to specialty care, improve chronic care management, and those designed to improve the patient experience. We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region’s health care system.

Project Valuation: This project’s value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation also

---


includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.  

---

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>EXPAND PEDIATRIC ACCESS TO RHEUMATOLOGY CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>139135109.3.7</td>
<td>IT-5.1</td>
</tr>
<tr>
<td></td>
<td>139135109.3.8</td>
<td>IT-5.2</td>
</tr>
<tr>
<td></td>
<td>139135109.3.9</td>
<td>IT-5.3</td>
</tr>
<tr>
<td></td>
<td>139135109.3.46</td>
<td>IT-1.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improved cost savings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Per Episode Cost of Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Length of Stay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Third Next Available Appointment</td>
</tr>
</tbody>
</table>

Texas Children’s Hospital

### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1 (P-1):**
Conduct specialty care gap assessment to determine barriers to accessing subspecialty care.

**Metric 1 (P-1.1):** Documentation of gap assessment

**Data Source:** Gap Assessment

**Milestone 1 Estimated Incentive Payment:** $503,264.50

**Milestone 2 (P-21):**
Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements.

### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 3 (I-23):**
Implement the re-design of Texas Children’s Gastroenterology Clinic to increase operational efficiency, increase provider productivity and increase clinic visits.

**Metric 1 (I-23.1):** Documentation of increased number of visits.

Demonstrate improvement over baseline reporting period (established in FY12).

**Data Source:** Registry, EHR

**Goal:** 5% increase over baseline or 83 additional visits compared to baseline

**Milestone 3 Estimated Incentive Payment:** $549,034.50

### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 5 (I-23):**
Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 (I-23.1):** Documentation of increased number of visits.

Demonstrate improvement over baseline reporting period (baseline established in FY12).

**Data Source:** EPIC medical record

**Goal:** 10% increase, or 165 additional visits compared to baseline

**Milestone 5 Estimated Incentive Payment:** $550,630.50

### Year 5 (10/1/2015 – 9/30/2016)

**Milestone 7 (I-23.1):**
Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 (I-23.1):** Documentation of increased number of visits.

Demonstrate improvement over baseline reporting period (baseline established in FY12).

**Data Source:** EPIC medical record

**Goal:** 15% increase, or 248 additional visits compared to baseline

**Milestone 7 Estimated Incentive Payment:** $454,868.50

**Milestone 8 (P-21):**
Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements.
<table>
<thead>
<tr>
<th>Metric 1 (P-21.1):</th>
<th>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,006,529</th>
<th>Year 3 Estimated Milestone Bundle Amount: $1,098,069</th>
<th>Year 4 Estimated Milestone Bundle Amount: $1,101,261</th>
<th>Year 5 Estimated Milestone Bundle Amount: $909,737</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</td>
<td>Goal: Participate in all semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>Goal: Participate in all semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>Goal: Participate in all semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>Goal: Participate in all semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $503,264.50</td>
<td>Milestone 4 Estimated Incentive Payment: $549,034.50</td>
<td>Milestone 6 Estimated Incentive Payment: $550,630.50</td>
<td>Milestone 8 Estimated Incentive Payment: $454,868.50</td>
<td>Metric 1 (P-21.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
</tr>
<tr>
<td>Improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td>Several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td>and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td>Metric 1 (P-21.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>Metric 1 (P-21.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $4,115,596</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Project Option 1.9.2- Expand Access to Specialty Care

Unique RHP Project ID: 139135109.1.4
Performing Provider Name/TPI: Texas Children’s Hospital/ 139135109

Project Summary: Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with congenital heart disease.

Provider:
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966</td>
<td>Medicaid and CHIP- 53.6%</td>
<td>Hispanic-</td>
</tr>
<tr>
<td>Births (babies delivered)-</td>
<td>Commercial Insurance- 40.6%</td>
<td>African American-</td>
</tr>
<tr>
<td>2,181</td>
<td>Self-Pay- 1.8%</td>
<td>Caucasian-</td>
</tr>
<tr>
<td>Emergency visits-113,586</td>
<td>Medicare- 1.2%</td>
<td>Asian-</td>
</tr>
<tr>
<td>Outpatient visits- 3,066,765</td>
<td></td>
<td>Other-</td>
</tr>
</tbody>
</table>

Intervention(s):
Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with congenital heart disease.

Need for the project:
Pediatric Cardiology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012).

Target Population:
All children with congenital heart disease ranging from neonate all the way through adulthood.

Category 1 or 2 expected patient benefits:
I-23.1: Our goal is to increase the number of visits by 3% in DY318,554 baseline visits; goal = 19,111 visits, by 5% in DY4 or 19,493, and by 7% in DY5 compared to baseline established in DY2 or 19,883.

Category 3 outcomes:
IT-5 Improving Cost of Care
IT 5.2: Per Episode Cost of Care
IT 5.3: Other Outcome Improvement Target: Reduced Length of Stay
IT-1.1: Third Next Available Appointment
Project Option- 1.9.2 Expand Access to Specialty Care: Pediatric Cardiology Care

Unique Project ID: 139135109.1.4
Performing Provider and TPI: Texas Children’s Hospital/139135109

Project Description:
Texas Children’s Hospital proposes to increase capacity in Cardiology Clinic.

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Specifically this project will increase capacity in our Cardiology Clinic. Through recruitment of additional highly-specialized Pediatric Cardiologists with focused training in subspecialized areas such as fetal cardiology, heart failure, adult congenital cardiology, pediatric electrophysiology, and pediatric interventional cardiology along with focused attention on existing provider productivity and increased efficiencies in patient throughput, this project will enable us to open clinics and increase appointment availability. In doing so, we will begin to improve access for the pediatric community needing general pediatric cardiac care as well as those populations who need the ultra-specialized pediatric and adult congenital cardiac care that we provide at Texas Children’s Hospital. This project also focuses on increasing Pediatric Cardiology presence at the 5 satellite locations across the greater Houston area to ensure we target the larger greater Houston population. Through partnerships with other organizations across the city and state, we will be expanding our specialized pediatric and adult congenital cardiac services to additional facilities throughout the greater Houston area as well as central Texas. Pediatric cardiology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). The Texas Children's ("TCH") Cardiology Service line is ranked #3 in the 2012 U.S. News and World Report Best Children's Hospitals and is the only pediatric cardiology service line ranked in the top 10 in Texas. Referrals into the TCH pediatric cardiology clinic increased significantly from a monthly average of 600 in 2010 to a monthly average of 760 in 2012.

Goals and Relationship to Regional Goals:
Project Goals: To meet the growing demand for specialized pediatric services TCH will:
- Focus on provider productivity to optimize clinical time for all providers
- Establish an initiative to review scheduling processes to increase the availability of these targeted providers
- Expand internal capacity by hiring additional clinical providers
• Enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also increase availability and scope of services in 1-3 additional community locations.

This project meets the following Region 3 Goals:
• Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
• Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients’ needs throughout the entire region, and improves health care outcomes and patient satisfaction.

As the demand for pediatric subspecialty services grows, TCH aims to maintain a consistent and significant presence for services at every subspecialty outpatient location in the TCH system. This increase in cardiology services capacity will allow children in our region to have more timely and appropriate access to much needed subspecialty care. We know from research that increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.

Challenges:
Recruitment of pediatric Cardiologists will be one of the larger challenges for this project due to the limited number of pediatric Cardiologists in the country which is compounded with the decreasing number of those currently in residency and fellowships focusing on pediatric cardiology. In order to attempt to resolve this challenge, TCH, and specifically pediatric cardiology, is funding additional fellowship training slots. This increase in trainees not only adds support for current patient care needs but helps face the challenge of declining pediatric cardiologists-in-training. Another challenge we will face with this project is the recruitment and retention of diagnostic and testing technologists. These technologists are highly specialized for pediatric cardiac diagnostics and are extremely difficult to recruit. With increased volume of patients, an increase in diagnostic studies is projected. We are developing partnerships with local training programs/schools to assist in on-site learning opportunities which will aid us in ultimately recruiting top students from those programs to support our additional patient capacity. In Texas, limited Medicaid reimbursement is an ongoing challenge for children’s hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children’s health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded.

Five year expected outcome for provider and patients:
Texas Children’s Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:
The baseline for patient volumes in FY 12 is 18,554. Our fiscal year runs from October 1st to September 30th.

**Rationale:**
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH’s existing pediatric and adult congenital cardiac services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. Specifically, we will provide comprehensive care for children within focused specialty programs, many of which are not offered at other local institutions, including: fetal cardiac imaging and consultation, adult congenital cardiology, heart failure/cardiomyopathy and transplantation, cardiac genetics follow-up, cardiac developmental outcomes for children who have undergone open-heart surgery, pediatric electrophysiology and pacing including the use of stereotaxis, and advanced pediatric interventional cardiology. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home. Increased access to appropriate care leads to better long term outcomes in children and reduction in unnecessary health care costs.

**Project Components:**
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

a. Conduct specialty care gap assessment based on community need for subspecialty.
b. Implement transparent standardized referrals across the system
c. Increase specialty care volume of visits and evidence of improved access for patients seeking services
d. Increase service availability hours and increase number of specialty clinic locations.
e. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges.

**Milestones and Metrics:**
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

**Unique community need identification number the project addresses:**
- CN.2: Inadequate access to specialty care,
- CN.6: Inadequate access to treatment and services designed for children.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Patients often experience lengthy wait times from the time they schedule the appointment to the time of the appointment; it can take weeks and, in some cases, months to see one of our providers. Funding for this project will allow us to significantly enhance our ability to see additional patients in a timelier manner and ensure the right patients are scheduled with the appropriate provider based on their specific specialized needs which will increase patient satisfaction and increase access to pediatric cardiac care. Our project will enable us to continue to grow our services at additional locations throughout the greater Houston area as well as some growth in Central Texas which is important because we are able to provide highly-specialized pediatric cardiac services that are not usually available at other institutions.

Related Category 3 Outcome Measure(s):
OD-5 Cost of Care
- IT 5.1: Improved Cost of Care
- IT 5.2: Per Episode Cost of Care
- IT 5.3: Length of Stay

OD-1 Primary Care and Chronic Disease Management
- IT-1.1: Third Next Available Appointment

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care services and subsequent costs.3 We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Relationship to other Projects: All of Texas Children’s projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

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

**Project Valuation:** This project’s value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^4\) Our valuation also includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.\(^5\) The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---


<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>A-D</th>
<th>EXPAND ACCESS TO SPECIALTY CARE: PEDIATRIC CARDIOLOGY CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.9.2</td>
<td>139135109.1.4</td>
<td>IT-5.1</td>
<td>139135109</td>
</tr>
<tr>
<td></td>
<td>139135109.3.10</td>
<td>IT-5.2</td>
<td>Improved Cost of Care</td>
</tr>
<tr>
<td></td>
<td>139135109.3.11</td>
<td>IT-5.3</td>
<td>Per Episode Cost of Care</td>
</tr>
<tr>
<td></td>
<td>139135109.3.12</td>
<td>IT-1.1</td>
<td>Length of Stay</td>
</tr>
<tr>
<td></td>
<td>139135109.3.47</td>
<td></td>
<td>Third Next Available Appointment</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Milestone 1</strong> [P-1]: Conduct specialty care gap assessment to determine barriers to accessing subspecialty care&lt;br&gt;<strong>Metric 1</strong> [P-1.1]: Documentation of gap assessment&lt;br&gt;  Goal: Perform and document gap assessment&lt;br&gt;  Data Source: Gap Assessment&lt;br&gt;  Milestone 1 Estimated Incentive Payment: $547,009</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Milestone 3</strong> [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services&lt;br&gt;  <strong>Metric 1</strong> [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12).&lt;br&gt;  Goal: Increase clinic volume by 3% over baseline (baseline = 18,554 visits; goal = 19,111 visits)&lt;br&gt;  Data Source: Registry, EHR&lt;br&gt;  Milestone 3 Estimated Incentive Payment: $596,757.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Milestone 5</strong> [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services&lt;br&gt;  <strong>Metric 1</strong> (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12).&lt;br&gt;  a. Total number of visits for reporting period&lt;br&gt;  b. Data Source: Registry, EHR&lt;br&gt;  Goal: Increase clinic volume by 5% over baseline or 19,493&lt;br&gt;  Milestone 5 Estimated Incentive Payment: $598,492</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td><strong>Milestone 7</strong> (I-23): Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services&lt;br&gt;  <strong>Metric 1</strong> (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12).&lt;br&gt;  a. Total number of visits for reporting period&lt;br&gt;  b. Data Source: Registry, EHR&lt;br&gt;  Goal: Increase clinic volume by 7% over baseline or 19,883&lt;br&gt;  Milestone 7 Estimated Incentive Payment: $494,406.50</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 2** [P-21]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements.

**Metric 1** [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.
### Expand Access to Specialty Care: Pediatric Cardiology Care

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>A-D</th>
<th>Expand Access to Specialty Care: Pediatric Cardiology Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>139135109.3.10</td>
<td>IT-5.1</td>
<td>Improved Cost of Care</td>
</tr>
<tr>
<td>139135109.3.11</td>
<td>IT-5.2</td>
<td>Per Episode Cost of Care</td>
</tr>
<tr>
<td>139135109.3.12</td>
<td>IT-5.3</td>
<td>Length of Stay</td>
</tr>
<tr>
<td>139135109.3.47</td>
<td>IT-1.1</td>
<td>Third Next Available Appointment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $547,009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $596,757.50</td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Initiatives that all providers can do to “raise the floor” for performance. Each participating provider should publicly commit to implementing these improvements. Metric 6 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $598,492</td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td>Initiatives that all providers can do to “raise the floor” for performance. Each participating provider should publicly commit to implementing these improvements. Metric 6 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $494,406.50</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount:** $(add incentive payments amounts from each milestone): $1,094,018

**Year 3 Estimated Milestone Bundle Amount:** $1,193,515

**Year 4 Estimated Milestone Bundle Amount:** $1,196,984

**Year 5 Estimated Milestone Bundle Amount:** $988,813

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $(add milestone bundle amounts over Years 2-5): $4,473,330
Project Option 1.9.2- Expand Access to Specialty Care

**Unique RHP Project ID:** 139135109.1.5  
**Performing Provider Name/TPI:** Texas Children’s Hospital/ 139135109

**Project Summary:** Increase outpatient access for Harris County, specifically North Houston, to care for pediatric patients with conditions affecting the lungs and respiratory tract.

**Provider:**
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966</td>
<td>Medicaid and CHIP- 53.6%</td>
<td>Hispanic-</td>
</tr>
<tr>
<td>Births (babies delivered)-</td>
<td>Commercial Insurance- 40.6%</td>
<td>African American-</td>
</tr>
<tr>
<td>2,181</td>
<td>Self-Pay- 1.8%</td>
<td>Caucasian-</td>
</tr>
<tr>
<td>Emergency visits-113,586</td>
<td>Medicare- 1.2%</td>
<td>Asian-</td>
</tr>
<tr>
<td>Outpatient visits- 3,066,765</td>
<td></td>
<td>Other-</td>
</tr>
</tbody>
</table>

**Intervention(s):**
Increase outpatient access for Harris County, specifically North Houston, to care for pediatric patients with conditions affecting the lungs and respiratory tract.

**Need for the project:**
Pediatric Pulmonology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012).

**Target Population:**
Our target population is patients seeking the full spectrum of services from general pulmonary care to treatment for life threatening conditions such cystic fibrosis and life threatening asthma.

**Category 1 or 2 expected patient benefits:**
I-23.1: Our goal is to increase the number of visits by 5% in DY3 or 272 additional visits compared to baseline, by 8% in DY4 or 436 additional visits compared to baseline, and by 10% in DY5 compared to baseline established in DY2, or 545 additional visits compared to baseline.

**Category 3 outcomes:**
OD 5 – Cost of Care  
IT-5 Improving Cost of Care
IT 5.2: Per Episode Cost of Care
IT 5.3: Other Outcome Improvement Target: Reduced Length of Stay
IT-1.1: Third Next Available Appointment
Project Options- 1.9.2 Expand Specialty Care Access: Pulmonology Pediatric Care

**Unique Project ID:** 139135109.1.5
**Performing Provider and TPI:** Texas Children’s Hospital/139135109

**Project Description:**
*Texas Children’s Hospital proposes to increase capacity in the Pulmonology Clinic, which will improve access to care and ensure reduce appointment wait time.*

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Specifically this project will increase capacity in our Pulmonology Clinic. Pediatric pulmonology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). The TCH Pulmonary Clinic receives an average of over 2,000 new patient referrals annually and that number can increase significantly during years of severe flu and respiratory virus outbreaks. The primary focus for this project will be increased availability at our community health centers in North Houston and surrounding areas where we currently have an average wait of 58 days for a new pulmonary appointment. This expansion into the community will also greatly benefit a significant number of our patients who do not have reliable transportation into the medical center and find it easier to access care in their own community at one of the above mentioned health centers. This increased availability will be accomplished by adding additional providers at those locations as well as optimizing current provider schedules to allow them so see more patients each day.

Additionally, we will focus on maintaining the accessibility of our lung transplant program by recruiting an additional faculty member to help care for this population of patients. Texas Children’s is one of busiest pediatric lung transplant programs in the country and has performed 9 transplants year to date in 2012. Only a handful of these programs exist in the United States and Texas Children’s is the only pediatric lung transplant program in the Southern region. Because there are so few pediatric lung programs in the country, there are inadequate training opportunities which have lead to a severe shortage of lung transplant trained physicians available to treat these patients. Our program helps children from around the country and the recruitment of an additional provider is vitally important if we are to maintain the viability of this program.

**Goals and Relationship to Regional Goals:**

**Project Goals:** To meet the growing demand for specialized pediatric services TCH will:
1. Focus on provider productivity to optimize clinical time for all providers
2. Establish an initiative to review scheduling processes to increase the availability of these targeted providers
3. Expand internal capacity by hiring additional clinical providers
4. Enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve the five additional community locations for specialty care.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients’ needs throughout the entire region, and improves health care outcomes and patient satisfaction

As the demand for pediatric subspecialty services grows, TCH aims to maintain a consistent and significant presence for services at every subspecialty outpatient location in the TCH system. This increase in pulmonology services capacity will allow children in our region to have more timely and appropriate access to much needed subspecialty care. We know from research that increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.

**Challenges:**
In Texas, limited Medicaid reimbursement is an ongoing challenge for children’s hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children’s health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of the waiver to ensure existing programs and services will be maintained and expanded.

**Five year expected outcome for provider and patients:**
Texas Children’s Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

**Starting Point/Baseline:**
The average wait time for an appointment for pulmonology at our two northern TCH health center locations is 58 days. The baseline for patient volumes in FY 12 is 5,450. Our fiscal year runs from October 1st to September 30th.

**Rationale:**
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH’s existing pulmonology services to improve patient satisfaction by
aspiring to provide the right care in the right setting at the right time. The Texas Children's ("TCH") Pulmonology Service line is ranked # 3 in the 2012 U.S. News and World Report Best Children's Hospitals and is the only pediatric pulmonology service line ranked in the top 10 in Texas. The TCH Pulmonary Service Line also boasts one of the largest lung transplant programs in the country and is currently recruiting an additional lung transplant physician in order to maintain access to this vital program for patients from across the country.

For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home. Increased access to appropriate care leads to better long term outcomes in children and reduction in unnecessary health care costs. Increasing pediatric population and continued lack of pediatric subspecialists due to the inequity in reimbursement between Medicaid and Medicare is an ongoing problem for children’s hospitals and the pediatric health care workforce.

**Project Components:**
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

- a. Conduct specialty care gap assessment based on community need for subspecialty.
- b. Implement transparent standardized referrals across the system
- c. Increase specialty care volume of visits and evidence of improved access for patients seeking services
- d. Increase service availability hours and increase number of specialty clinic locations.
  Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges.

**Milestones and Metrics**
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-21 (P-21.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

**Unique community need identification numbers the project addresses:**
- CN.2: Inadequate access to specialty care.
- CN.6: Inadequate access to treatment and services designed for children.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
Patients often experience lengthy wait times from the time they schedule the appointment to the time of the appointment; it can take weeks and, in some cases, months to see one of our providers. Funding for this project will allow us to significantly enhance our ability to see

---

additional patients in a timelier manner and ensure the right patients are scheduled with the appropriate provider based on their specific specialized needs which will increase patient satisfaction and increase access to care. Our project will enable us to continue to grow our services at additional locations throughout the greater Houston area which is important because we are able to provide highly-specialized pediatric pulmonary services that are not usually available at other institutions.

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

OD-5 Cost of Care  
IT-5.1: Improved cost savings  
IT-5.2: Per episode of care cost  
IT-5.3: Length of stay  

OD-1 Primary Care and Chronic Disease Management  
IT-1.1: Third Next Available Appointment

**Reasons/rationale for selecting the outcome measures:**

Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care services and subsequent costs. Because of the continued growth in demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The Affordable Care Act focused on the triple aim-improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Relationship to other Projects:** All of Texas Children’s projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum).

**Plan for Learning Collaborative:** We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects

---

will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region’s health care system.

**Project Valuation:** This project’s value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^4\) Our valuation also includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.\(^5\) The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.


## Expand Specialty Care Access: Pulmonology Pediatric Care

**Texas Children’s Hospital**

<table>
<thead>
<tr>
<th>Related Category</th>
<th>Outcome Measure(s):</th>
<th>A-D</th>
<th>Expected Cost Savings</th>
<th>Per Episode of Care Cost</th>
<th>Length of Stay</th>
<th>Third Next Available Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.9.2</td>
<td>139135109.3.13</td>
<td>IT-5.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>139135109.3.14</td>
<td>IT-5.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>139135109.3.15</td>
<td>IT-5.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>139135109.3.48</td>
<td>IT-1.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1 (P-1):** Conduct specialty care gap assessment to determine barriers to accessing subspecialty care

**Metric 1 (P-1.1):** Documentation of gap assessment  
Data Source: Gap Assessment

Milestone 1 Estimated Incentive Payment: $539,963

**Milestone 2 (P-21):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

**Metric 1 (P-21.1):**  
Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 3 (I-23):** Implement the re-design of Texas Children’s Pulmonary Clinic to increase provider productivity and increase specialty care clinic visits and evidence of improved access for patients seeking services.

**Metric 1 (I-23.1):** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12).  
Goal: 5% increase above the baseline, or 272 additional visits compared to baseline  
Data Source: EPIC medical record

Milestone 3 Estimated Incentive Payment: $589,070.50

**Milestone 4 (P-21):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 5 (I-23):** Continue to increase specialty care clinic visits and evidence of improved access for patients seeking services.

**Metric 1 (I-23.1):** Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (baseline established in FY12).  
Goal: 8% increase above the baseline, or 436 additional visits compared to baseline  
Data Source: EPIC medical record

Milestone 5 Estimated Incentive Payment: $590,783

**Milestone 6 (P-21):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

### Year 5 (10/1/2015 – 9/30/2016)

**Milestone 7 (I-23):** Continue to increase specialty care clinic volume visits and evidence of improved access for patients seeking services.

**Metric 1 (I-23.1):** Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (baseline established in FY12).  
Goal: 10% increase above the baseline, or 545 additional visits compared to baseline  
Data Source: EPIC medical record

Milestone 7 Estimated Incentive Payment: $488,038

**Milestone 8 (P-21):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>IT-5.1</th>
<th>IT-5.2</th>
<th>IT-5.3</th>
<th>IT-1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>139135109.3.13</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>139135109.3.14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>139135109.3.15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>139135109.3.48</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Year 2
(10/1/2012 – 9/30/2013)

Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

Milestone 2 Estimated Incentive Payment: $539,963

### Year 3
(10/1/2013 – 9/30/2014)

Metric 1 (P-21.1):
Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

Milestone 4 Estimated Incentive Payment: $589,070.50

### Year 4
(10/1/2014 – 9/30/2015)

Metric 1 (P-21.1):
Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

Milestone 6 Estimated Incentive Payment: $590,783

### Year 5
(10/1/2015 – 9/30/2016)

Metric 1 (P-21.1):
Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

Milestone 8 Estimated Incentive Payment: $488,038

### Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,079,926

### Year 3 Estimated Milestone Bundle Amount: $1,178,141

### Year 4 Estimated Milestone Bundle Amount: $1,181,566

### Year 5 Estimated Milestone Bundle Amount: $976,076

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $4,415,709**
Project Option 1.9.2- Expand Access to Specialty Care

Unique RHP Project ID: 139135109.1.6
Performing Provider Name/TPI: Texas Children’s Hospital/ 139135109

Project Summary: Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with Ophthalmological needs which may possibly include surgical interventions.

Provider:
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966</td>
<td>Medicaid and CHIP- 53.6%</td>
<td>Hispanic-</td>
</tr>
<tr>
<td>Births (babies delivered)- 2,181</td>
<td>Commercial Insurance- 40.6%</td>
<td>African American-</td>
</tr>
<tr>
<td>Emergency visits-113,586</td>
<td>Self-Pay- 1.8%</td>
<td>Caucasian-</td>
</tr>
<tr>
<td>Outpatient visits- 3,066,765</td>
<td>Medicare- 1.2%</td>
<td>Asian-</td>
</tr>
</tbody>
</table>

Intervention(s): The division is working to expand its services and increase outpatient access by utilizing the addition of an Optometrist. As well as in the next 5 years the Ophthalmology division would like to grow its services with programs such as Ocular Trauma, Ocular Plastics, Pediatric Glaucoma, and focus of the Retina and Cornea pediatric Patients.

Need for the project: Pediatric Ophthalmology is an identified both at the national and state level to have a shortage of resources to meet consumer demands (Children’s Hospital Association – Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). There are providers who also not only focus on the pediatric population but also the adult

Target Population:
Our target population is pediatric patients with Ophthalmological needs which may possibly include surgical interventions. Untreated care of these patients due to the inability to provide quick access to our services, can lead to less or reduced eyesight.

Category 1 or 2 expected patient benefits:
I-23.1: Our goal is to increase the number of visits by 3% in DY3 which is an additional 460 patient visits from the baseline. by 3% in DY4 which is an additional 934 patient visits from the baseline, and by 6% in DY5 which is an additional 1,422 patient visits from the baseline.

Category 3 outcomes:
OD 5 Cost of Care
IT-5 Improving Cost of Care
IT 5.2: Per Episode Cost of Care
IT 5.3: Other Outcome Improvement Target: Reduced Length of Stay

OD 1 Primary Care and Chronic Disease Management
IT-1.1: Third Next Available Appointment
Project Option- 1.9.2 Expand Access to Specialty Care: Pediatric Ophthalmology Care

**Unique Project ID:** 139135109.1.6  
**Performing Provider and TPI:** Texas Children’s Hospital/139135109

**Project Description:**  
*Texas Children’s Hospital will increase capacity in the Ophthalmology Clinic to expand access and reduce appointment wait times.*

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Specifically this project will increase capacity in our Ophthalmology Clinic. Pediatric Ophthalmology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). Currently the division is working to expand its services by utilizing the addition of an Optometrist. The Optometrists are able see the division’s lower acuity patients freeing up our Ophthalmic Surgeons to see more complex patients in clinic as well as increase their time spent in the Operating Room. They would be able to screen all the patients and determine if they are a surgical candidate or not. In the next 5 years the Ophthalmology division has several areas in which it would like to grow its services. These new programs include Ocular Trauma, Ocular Plastics, Pediatric Glaucoma, and focus of the Retina and Cornea of pediatric patients. TCH uses the industry standard of 3rd available appointment as a measure of access to care - ideal access would be less than 14 days. For the majority of FY10 and FY11, the average 3rd available appointment at the TCH Ophthalmology clinic is greater than 14 days.

**Goals and Relationships to Regional Goals:**

**Project Goals:** To meet the growing demand for specialized pediatric services TCH will:

1. Focus on provider productivity to optimize clinical time for all providers  
2. Establish an initiative to review scheduling processes to increase the availability of these targeted providers  
3. Expand internal capacity by hiring additional clinical providers  
4. Enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve 1-3 additional community locations for rheumatology care Focus on provider productivity to optimize clinical time for all providers and enhance training of subspecialists and fellows.
This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients’ needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges:
One of the challenges we face is that these providers not only focus on the pediatric population but also the adult. Another challenge is the untreated or delay in care for these patients and if we are unable to provide quick access to our services, that can lead to less or reduced eyesight. For many patient families, vision problems aren’t readily diagnosed at the primary care visit or discussed as other health problems may dominate the conversation during that patient visit. In Texas, limited Medicaid reimbursement is an ongoing challenge for children’s hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children’s health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded.

Five year expected outcome for provider and patients:
Texas Children’s Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:
The baseline for patient volumes in FY 12 is 15,333. Our fiscal year runs from October 1st through September 30th. The average 3rd Next available appointment across all locations of care in FY’12 was 18 days for a New Patient Visit.

Rationale:
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH’s existing Ophthalmology pediatric services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. Specifically, we will strive to provide comprehensive care for children within focused specialty programs and expand clinical focus upon small but very acute patient needs.

Increasing pediatric population and continued lack of pediatric subspecialists due to the inequity in reimbursement between Medicaid and Medicare is an ongoing problem for children’s hospitals and the pediatric health care workforce.

Project Components:
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

a. Conduct specialty care gap assessment based on community need for subspecialty.
b. Implement transparent standardized referrals across the system
c. Increase specialty care volume of visits and evidence of improved access for patients seeking services
d. Increase service availability hours and increase number of specialty clinic locations.
e. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges. It is our goal to reach the industry standard of less than 14 days for the 3rd available appointment.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.1

**Milestones and Metrics**
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-21(P-21.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

**Unique community need identification number the project addresses:**
- CN.2: Inadequate access to specialty care,
- CN.6: Inadequate access to treatment and services designed for children.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
Our project will enable us to continue to grow our services at additional locations as well as increase capacity through programmatic growth and new Physician and NPP recruitment. We will be able to increase access to care so that patients are not left with untreated conditions. In addition, with our project we would have pediatric focused MDs caring for Pediatric Patients.

**Related Category 3 Outcome Measures:**

OD-5 Cost of Care
IT-5.1: Improved cost savings
IT-5.2: Per episode of care cost
IT-5.3: Length of stay
OD -1 Primary Care and Chronic Disease Management
IT-1.1: Third Next Available Appointment

**Reasons/rationale for selecting the outcome measures:**

Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs. Due to continued growth in demand for patient care services, the outcome measure of 3rd next available appointment must be considered in addition to the metric of patient visit volume growth, compared to the baseline to be able to truly measure patient access. While at the same time we are striving to increase patient access we will need to continue to focus on delivering quality, efficient, cost effective care.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:** This project will compliment other projects designed to improve appropriate access to specialty care, improve chronic care management, and those designed to improve the patient experience. We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region’s health care system.

**Project Valuation:** This project’s value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation also includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 (P-1):</strong> Conduct specialty care gap assessment to determine barriers to accessing subspecialty care</td>
<td><strong>Milestone 2 (P-21):</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td><strong>Milestone 3 (P-17):</strong> Implement process improvements of Texas Children’s Ophthalmology Clinic to increase operational efficiency, shorten patient cycle time and increase provider productivity. Increase clinic volume of visits and evidence of improved access for patients seeking services. <strong>Metric 1 (P-17.1):</strong> Number of specialty clinics that have completed clinic redesign. Demonstrate improvement over prior reporting period (baseline established in FY12). Documentation of increased number of visits. Total number of visits for reporting period Data Source: Specialty clinic Warehouse, HR staffing and timesheets Goal: Increase clinic volume 3% across all locations of care which is an additional 934 patient visits from the baseline Data Source: Epic/Enterprise Data Warehouse, HR staffing and timesheets</td>
<td><strong>Milestone 4 (P-21):</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing</td>
</tr>
</tbody>
</table>
| **Metric 1 [P-1.1] Documentation of gap assessment**  
Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment: $614,780 | **Milestone 3 (P-17):** Implement process improvements of Texas Children’s Ophthalmology Clinic to increase operational efficiency, shorten patient cycle time and increase provider productivity. Increase clinic volume of visits and evidence of improved access for patients seeking services. **Metric 1 (P-17.1):** Number of specialty clinics that have completed clinic redesign. Demonstrate improvement over prior reporting period (baseline established in FY12). Documentation of increased number of visits. Total number of visits for reporting period Data Source: Specialty clinic Warehouse, HR staffing and timesheets Goal: Increase clinic volume 3% across all locations of care which is an additional 934 patient visits from the baseline Data Source: Epic/Enterprise Data Warehouse, HR staffing and timesheets | **Milestone 5 (I-23):** Increase clinic volume of visits and evidence of improved access for patients seeking services. **Metric 1 (I-23.1):** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). Goal: Increase clinic volume 3% across all locations of care which is an additional 934 patient visits from the baseline Data Source: Epic/EDW Milestone 5 Estimated Incentive Payment: $672,642 | **Milestone 7 (I-23):** Increase clinic volume of visits and evidence of improved access for patients seeking services. **Metric 1 (I-23.1):** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). Goal: 6% over baseline which is an additional 1,422 patient visits from the baseline Data Source: Epic/EDW Milestone 7 Estimated Incentive Payment: $ 555,661 |
<p>| <strong>Milestone 2 (P-21):</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. | <strong>Milestone 3 (P-17):</strong> Implement process improvements of Texas Children’s Ophthalmology Clinic to increase operational efficiency, shorten patient cycle time and increase provider productivity. Increase clinic volume of visits and evidence of improved access for patients seeking services. <strong>Metric 1 (P-17.1):</strong> Number of specialty clinics that have completed clinic redesign. Demonstrate improvement over prior reporting period (baseline established in FY12). Documentation of increased number of visits. Total number of visits for reporting period Data Source: Specialty clinic Warehouse, HR staffing and timesheets Goal: Increase clinic volume 3% across all locations of care which is an additional 934 patient visits from the baseline Data Source: Epic/Enterprise Data Warehouse, HR staffing and timesheets | <strong>Milestone 4 (P-21):</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing |
| <strong>Milestone 4 (P-21):</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing | <strong>Milestone 5 (P-23):</strong> Increase clinic volume of visits and evidence of improved access for patients seeking services. <strong>Metric 1 (P-23.1):</strong> Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). Goal: Increase clinic volume 3% across all locations of care which is an additional 934 patient visits from the baseline Data Source: Epic/EDW Milestone 5 Estimated Incentive Payment: $672,642 | <strong>Milestone 6 (P-21):</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing | <strong>Milestone 8 (P-21):</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing |</p>
<table>
<thead>
<tr>
<th>139135109.1.6</th>
<th>1.9.2</th>
<th>A-D</th>
<th>EXPAND ACCESS TO SPECIALTY CARE: PEDIATRIC OPHTHALMOLOGY CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Texas Children’s Hospital</td>
</tr>
<tr>
<td>Related Category 3</td>
<td>Outcome Measure(s):</td>
<td>IT-5.1</td>
<td>Improved cost savings</td>
</tr>
<tr>
<td>139135109.3.16</td>
<td>139135109.3.16</td>
<td>IT-5.2</td>
<td>Per episode of care cost</td>
</tr>
<tr>
<td>139135109.3.17</td>
<td>139135109.3.17</td>
<td>IT-5.3</td>
<td>Length of stay</td>
</tr>
<tr>
<td>139135109.3.18</td>
<td>139135109.3.18</td>
<td>IT-1.1</td>
<td>Third Next Available Appointment</td>
</tr>
<tr>
<td>139135109.3.49</td>
<td>139135109.3.49</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

- **Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

- **Milestone 2 Estimated Incentive Payment:** $614,780

  - **Metric 1 [P-21.1]:** Participate in semiannual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

  - **Milestone 4 Estimated Incentive Payment:** $670,692.50

  - **Metric 1 [P-21.1]:** Participate in semiannual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

  - **Milestone 6 Estimated Incentive Payment:** $672,642

  - **Metric 1 [P-21.1]:** Participate in semiannual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

  - **Milestone 8 Estimated Incentive Payment:** $555,661

- **Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $1,229,560

- **Year 3 Estimated Milestone Bundle Amount:** $1,341,385

- **Year 4 Estimated Milestone Bundle Amount:** $1,345,284

- **Year 5 Estimated Milestone Bundle Amount:** $1,111,322
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>1.9.2</th>
<th>A-D</th>
<th>EXPAND ACCESS TO SPECIALTY CARE: PEDIATRIC OPHTHALMOLOGY CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Texas Children’s Hospital</td>
<td>139135109</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IT-5.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>139135109.3.16</td>
<td>IT-5.2</td>
<td>Improved cost savings</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IT-5.3</td>
<td>Per episode of care cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>139135109.3.17</td>
<td>IT-1.1</td>
<td>Length of stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>139135109.3.18</td>
<td></td>
<td>Third Next Available Appointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>139135109.3.49</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $5,027,551</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Project Option 1.9.2- Expand Access to Specialty Care

Unique RHP Project ID: 139135109.1.7

Performing Provider Name/TPI: Texas Children’s Hospital/ 139135109

Project Summary: Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with conditions affecting the digestive system.

Provider:
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966</td>
<td>Medicaid and CHIP- 53.6%</td>
<td>Hispanic-</td>
</tr>
<tr>
<td>Births (babies delivered)- 2,181</td>
<td>Commercial Insurance- 40.6%</td>
<td>African American-</td>
</tr>
<tr>
<td>Emergency visits-113,586</td>
<td>Self-Pay- 1.8%</td>
<td>Caucasian-</td>
</tr>
<tr>
<td>Outpatient visits- 3,066,765</td>
<td>Medicare- 1.2%</td>
<td>Asian-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>American Indian-</td>
</tr>
</tbody>
</table>

Intervention(s):
Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with conditions affecting the digestive system.

Need for the project:
Pediatric Gastroenterology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012).

Target Population:
Our target population is patients seeking the full spectrum of services from general digestive and liver care to quartenary programs for Inflammatory Bowel Disease, Intestinal Rehabilitation, Neurogastroenterology and Motility, Viral Hepatitis, Eosinophilic Gastrointestinal Disorders and Hepatobiliary Disease.

Category 1 or 2 expected patient benefits:
I-23.1: Our goal is to increase the number of visits by 10% in DY3 over baseline or 1978 patients, by 15% in DY4 over baseline or 2967, and by 20% in DY5 over baseline or 3956 patients.
Category 3 outcomes:
IT-5 Improving Cost of Care
IT 5.2: Per Episode Cost of Care
IT 5.3: Other Outcome Improvement Target: Reduced Length of Stay

OD1 Primary Care and Chronic Disease Management
IT-1.1: Third Next Available Appointment
Project Description:  
Texas Children’s Hospital proposes to increase access for children to pediatric subspecialty services in the gastroenterology, hepatology and nutrition (GHN) clinic.

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

The proposed project seeks to increase access for children to pediatric subspecialty services in the gastroenterology, hepatology and nutrition (GHN) clinic at Texas Children’s Hospital (“TCH”). Access to GHN services has been identified, both at the national and state level, as problematic (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012); barriers include a shortage of trained subspecialists, the geographic concentration of subspecialists in major urban areas and growing patient demand. The Texas Children's Gastroenterology, Hepatology and Nutrition service is ranked # 4 in the 2012 U.S. News and World Report Best Children's Hospitals and is the only pediatric gastroenterology service line ranked in the top 10 in Texas. The GHN service provides care at Texas Children’s Main Campus, Texas Children’s West Campus, four community Health Centers located in Harris County as well as the pediatric subspecialty clinic of Harris Health System. Though GHN serves children with routine digestive and liver diseases such as abdominal pain, gastroesophageal reflux, failure-to-thrive and hepatitis, Texas Children’s GHN service is also home to the largest pediatric liver transplant program in the United States (34 transplants performed year-to-date), and the only program in the Southwestern United States. A number of quaternary care programs have been developed, including Inflammatory Bowel Disease, Intestinal Rehabilitation, Neurogastroenterology and Motility, Viral Hepatitis, Eosinophilic Gastrointestinal Disorders and Hepatobiliary Disease. The GHN service also provides a complete range of diagnostic and therapeutic endoscopy procedures, many of which are not available anywhere else in Texas.

The number of children referred to Texas Children’s GHN clinics increased significantly from a monthly average of 950 in 2010 to a monthly average of more than 1,300 in 2012. We anticipate this number will continue to grow due to recent external GHN practice reductions and closures in Texas and neighboring regions. The clinic now serves as a frequent regional referral site for multiple states in the south, including Arizona, New Mexico, Louisiana, Mississippi, Alabama and Florida. The program currently accepts three pediatric gastroenterology fellows per training
year (total of nine), and is thereby doing its part to train and replenish other communities with quality pediatric subspecialty physicians.

Specifically, this project will increase capacity in our gastroenterology, hepatology and nutrition (GHN) clinic. Pediatric gastroenterology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). TCH uses the industry standards of 3rd available appointment and total annual as measures of access to care. However, given the high demand and provider shortage, for the majority of Fiscal Year 2010 and Fiscal Year 2011, the average 3rd available appointment at the TCH gastroenterology clinic is greater than 30 days. The increased focus on the prevalence of childhood obesity at both the national and state levels has added additional pressure on the clinic because 47.3% of children in Harris County are classified as either overweight or obese according to the 2012 FITNESSGRAM assessment (Children at Risk - Growing Up in Houston: Assessing the Quality of Life of Our Children; 2012 -2014 edition).

As the demand for pediatric subspecialty services grows, TCH aims to maintain a consistent and significant presence for services at every subspecialty outpatient location in the TCH system. This increase in gastroenterology service capacity will allow children in our region to have more timely and appropriate access to much needed subspecialty care. We know increased access to appropriate care leads to better long term outcomes in children and reduction in unnecessary health care costs.¹

Goals and Relationship to Regional Goals:

Project Goals: To meet the growing demand for specialized pediatric services, TCH will enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve 1-3 additional community locations for gastrointestinal specialty clinics and on provider productivity to optimize clinical time for all providers and enhance training of subspecialists and fellows by:

- Increase the number of patients seen in GHN clinics by focusing on provider productivity to optimize clinical time for all providers, and establishing an initiative to review scheduling processes to increase the availability of these targeted providers
- Decrease time from initial referral to appointment
- Expand internal capacity by hiring additional clinical providers
- Provide training and outreach to local and regional practitioners

This project meets the following Region 3 Goals:

Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care. Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients’ needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Challenges:
The need for pediatric gastroenterology subspecialists is underserved nationally. The current number of gastroenterology fellows in training across the nation is inadequate to meet the growing demand. Our training program consistently seeks out and successfully recruits the brightest talent from across the country each year, due to its national reputation. Over the past five years, our trainees have gone on to not only serve in our community, but also in multiple underserved communities in South Texas. Additionally, in Texas, limited Medicaid reimbursement is an ongoing challenge for children’s hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children’s health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of the waiver to ensure existing programs and services will be maintained and expanded.

Five year expected outcome for provider and patients:
Texas Children’s Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:
The baseline for patient volumes in Fiscal Year 2012 across all locations of care is 19,780. Our fiscal year runs from October 1st to September 30th.

Rationale:
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH’s existing gastroenterology services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. Specifically, we will provide comprehensive care for children within focused specialty programs such as: liver transplant, fatty liver, viral hepatitis, motility, inflammatory bowel disease or eosinophilic disease.

Increasing pediatric population and continued lack of pediatric subspecialists due to the inequity in reimbursement between Medicaid and Medicare is an ongoing problem for children’s hospitals and the pediatric health care workforce.
Project Components: Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

a. Conduct specialty care gap assessment based on community need for subspecialty.
b. Implement transparent standardized referrals across the system
c. Increase specialty care volume of visits and evidence of improved access for patients seeking services
d. Increase service availability hours and increase number of specialty clinic locations.
e. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.\(^2\)

Milestones and Metrics
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-21 (P-21.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

Unique community need identification number the project addresses:
- CN.2: Inadequate access to specialty care,
- CN.6: Inadequate access to treatment and services designed for children.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project will enhance current services by expanding and maximizing provider accessibility that will result in a greater number of patients served. In addition it will result in prompt service and allow more children access to GI subspecialty care.

Related Category 3 Outcome Measure(s):
OD -5: Cost of Care
IT – 5.1: Improved Cost Savings
IT – 5.2: Per Episode Cost of Care
IT – 5.3: Length of Stay

OD-1 Primary Care and Chronic Disease Management
IT-1.1: Third Next Available Appointment

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care

costs. Because of the continued growth in demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access.

**Relationship to other Projects:** All of Texas Children’s projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Future medication and technological advances in the diagnosis and subsequent care of pediatric diseases will dictate the treatments needed as well as the cost of healthcare in future years, so it is critical that children receive the appropriate access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region.

(addendum)

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

**Project Valuation:** This project’s value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation also includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.

---


<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>IMPROVE ACCESS TO SPECIALTY CARE: EXPAND PEDIATRIC GASTROENTEROLOGY CARE</th>
<th>139135109</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.9.2</td>
<td>A-D</td>
<td></td>
<td>139135109</td>
</tr>
</tbody>
</table>

**Texas Children’s Hospital**

### Year 2
(10/1/2012 – 9/30/2013)

**Milestone 1 (P-1):**
Conduct specialty care gap assessment to determine barriers to accessing subspecialty care
**Metric 1 (P-1.1):**
Documentation of gap assessment
Data Source: Gap Assessment

Milestone 1 Estimated Incentive Payment: $1,074,372.50

### Year 3
(10/1/2013 – 9/30/2014)

**Milestone 3 (I-23):**
Implement the re-design of Texas Children’s Gastroenterology Clinic to increase operational efficiency, increase provider productivity and increase clinic visits.

**Metric 1 (I-23.1):**
Documentation of increased number of visits.
Demonstrate improvement over baseline reporting period (established in FY12).

Milestone 3 Estimated Incentive Payment: $1,172,083

### Year 4
(10/1/2014 – 9/30/2015)

**Milestone 5 (I-23):**
Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 (I-23.1):**
Documentation of increased number of visits.
Demonstrate improvement over baseline reporting period (baseline established in FY12).

Milestone 5 Estimated Incentive Payment: $1,175,490

### Year 5
(10/1/2015 – 9/30/2016)

**Milestone 7 (I-23):**
Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 (I-23.1):**
Documentation of increased number of visits.
Demonstrate improvement over prior reporting period (baseline established in FY12).

Milestone 7 Estimated Incentive Payment: $500,000

### Milestone 8 (P-21):
Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. <strong>Milestone 2 Estimated Incentive Payment:</strong> $1,074,372.50</td>
<td>should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. <strong>Metric 1 (P-21.1):</strong> Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. <strong>Milestone 4 Estimated Incentive Payment:</strong> $1,172,083</td>
<td>should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. <strong>Metric 1 (P-21.1):</strong> Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. <strong>Milestone 6 Estimated Incentive Payment:</strong> $1,175,490</td>
<td>(simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. <strong>Metric 1 (P-21.1):</strong> Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. <strong>Milestone 8 Estimated Incentive Payment:</strong> $500,000</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $2,148,745

**Year 3 Estimated Milestone Bundle Amount:** $2,344,166

**Year 4 Estimated Milestone Bundle Amount:** $2,350,980

**Year 5 Estimated Milestone Bundle Amount:** $1,000,000

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $8,786,004
Project Option 1.9.2- Expand Access to Specialty Care

Unique RHP Project ID: 139135109.1.8
Performing Provider Name/TPI: Texas Children’s Hospital/ 139135109

Project Summary: Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with conditions affecting the endocrine system.

Provider:
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966</td>
<td>Medicaid and CHIP- 53.6%</td>
<td>Hispanic-</td>
</tr>
<tr>
<td>Births (babies delivered)- 2,181</td>
<td>Commercial Insurance- 40.6%</td>
<td>African American-</td>
</tr>
<tr>
<td>Emergency visits- 113,586</td>
<td>Self-Pay- 1.8%</td>
<td>Caucasian-</td>
</tr>
<tr>
<td>Outpatient visits- 3,066,765</td>
<td>Medicare- 1.2%</td>
<td>Asian-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>American Indian-</td>
</tr>
</tbody>
</table>

Intervention(s):
Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with conditions affecting the endocrine system.

Need for the project:
Pediatric Diabetes/Endocrinology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012).

Target Population:
Our target population is patients seeking the full spectrum of services for metabolic syndrome, type I, and type II diabetes. In particular, the focus is on patients who are at risk for diabetic retinopathy, the leading cause of blindness for those diagnosed with diabetes.

Category 1 or 2 expected patient benefits:
I-23.1: Our goal is to increase the number of visits by 10% in DY3 or 1,622 additional visits compared to baseline, by 15% in DY4 or 2,434 additional visits compared to baseline, and by 20% in DY5 or 3,245 additional visits compared to baseline.

Category 3 outcomes:
IT-5 Improving Cost of Care
IT 5.2: Per Episode Cost of Care
IT 5.3: Other Outcome Improvement Target: Reduced Length of Stay
IT-1.1: Third Next Available Appointment
Project Option: 1.9.2 Expand Specialty Care Capacity Diabetes: Endocrinology Pediatric Care

Unique Project ID: 139135109.1.8

Performing Provider Name/TPI: Texas Children’s Hospital/ 139135109

Project Description:
*Texas Children’s Hospital proposes to expand access to pediatric care in diabetes and endocrinology.*

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Our project proposal will significantly improve access to pediatric subspecialty care in diabetes and endocrinology. Funding for this project will allow Texas Children’s to fulfill our tri-part mission of providing quality pediatric care, training the next generation of pediatric providers and investigating ways to improve care through innovative therapies. Pediatric diabetes/endocrinology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). The Texas Children's ("TCH") Diabetes / Endocrine Service line is ranked # 14 in the 2012 *U.S. News and World Report* Best Children's Hospitals. The Diabetes/Endocrine Service at TCH has purchased a retinal camera for screening of patients ≥10 years of age. This camera will help to track and manage patients ≥10 years of age who have had diabetes for >5 years. These patients are at risk for diabetic retinopathy, the leading cause of blindness for those diagnosed with diabetes. The American Diabetes Association recommends yearly screening for diabetic retinopathy. The majority of our patients do not receive this screening due to socioeconomic challenges and lack of availability. Our improved service increases access to screening and minimizes impact on a parent’s time away from work. The TCH Diabetes/Endocrine Section, next to Barbara Davis, will be the only outpatient clinic to provide this service to patients with Type I/II diabetes.

Referrals into the TCH pediatric diabetes/endocrinology clinic are at a monthly average of 500 in 2012. TCH uses 3rd available and total annual volume increase as two of the metrics to measure access.

Goals and Relationship to Regional Goals:

Project Goals:
To meet the growing demand for acute pediatric diabetes/endocrinology services, TCH will:

1. Initiate processes to increase provider productivity, optimizing provider clinical time and enhancing training of subspecialists and fellows.
2. Streamline processes for patient scheduling, thus increasing availability of provider appointments.
3. Expand provider capacity by hiring additional clinicians and support staff.
4. Enhance service availability by delivering patient care closer to where patients live rather than only in a centralized location (Texas Medical Center). We will continue to expand access at our community locations for specialty care.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients’ needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Challenges:

In Texas, limited Medicaid reimbursement is an ongoing challenge for children’s hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children’s health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of the waiver to ensure existing programs and services will be maintained and expanded. Increased access to clinical care has unexpectedly led to increased demand for our services. Our goal is to match access to demand, which may require additional reconfigurations of clinic processes, schedules, and staffing.

Five year expected outcome for provider and patients:

Texas Children’s Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:

The baseline for patient volumes in FY 12 is 16,226 visits across all locations of care. Our fiscal year runs from October 1st to September 30th.
**Rationale:** As the pediatric patient population grows in our area so does the prevalence of diseases needing care and treatment by subspecialists. Specifically, in Texas, and in particular, Houston/Harris, more children are being diagnosed with metabolic syndrome, diabetes and obesity: 47.3% of children in Harris County are classified as either overweight or obese according to the 2012 FITNESSGRAM assessment (Children at Risk - Growing Up in Houston: Assessing the Quality of Life of Our Children; 2012 -2014 edition).

Type II diabetes and other hormonal disorders can be attributed to this disease which in turn strains a health care system that lacks these highly trained subspecialists, especially, in a state whose population is dramatically increasing. Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home. The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH’s existing pediatric diabetes and endocrine services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. In order to increase access

**Project Components:**
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

- Conduct specialty care gap assessment based on community need for subspecialty.
- Implement transparent standardized referrals across the system
- Increase specialty care volume of visits and evidence of improved access for patients seeking services
- Increase service availability hours and increase number of specialty clinic locations.
- Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.¹

**Milestones and Metrics**
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-21 (P-21.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

Customizable Improvement Milestone and Metric was chosen in order to specifically tailor the intent of project to the targeted pediatric population.

---

Unique community need identification number the project addresses:

- CN.2: Inadequate access to specialty care,
- CN.6: Inadequate access to treatment and services designed for children.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
The overall goal of this project is increased access. Expanding clinical appointments coupled with clinical efficiencies will significantly enhance delivery of patient care by providing unavailable and/or unprecedented levels of clinical service. Additional appointment availability will allow much more frequent interventions in diabetes and endocrinology patient care management, which result in improved clinical outcomes.

Related Category 3 Outcome Measure(s):
OD-5 Cost of Care
IT-5.1: Improved cost savings
IT-5.2: Per episode of care cost
IT-5.3: Length of stay

OD-1 Primary Care and Chronic Disease Management
IT-1.1: Third Next Available Appointment

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs. Because of the continued growth in demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The Affordable Care Act focused on the triple aim – improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Relationship to other Projects: All of Texas Children’s projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved

---

cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

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

**Project Valuation:** This project’s value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation also includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.³

---


<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 (P-1):</strong></td>
<td>Conduct specialty care gap assessment to determine barriers to accessing subspecialty care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 (P-1,1):</td>
<td>Documentation of gap assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Gap Assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $1,074,372.50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 2 (P-21):</strong></td>
<td>Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 (P-21,1):</td>
<td>Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3 (I-23):</strong></td>
<td>Increase specialty care clinic volume and improve access for patients seeking services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 (I-23,1):</td>
<td>Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (established in FY12).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Total number of visits for reporting period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Data Source: Registry, EHR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: 10% increase, or 1,622 additional visits compared to baseline</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 4 (P-21):</strong></td>
<td>Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5 (I-23):</strong></td>
<td>Increase specialty care clinic volume and improve access for patients seeking services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 (I-23,1):</td>
<td>Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (established in FY12).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Total number of visits for reporting period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Data Source: Registry, EHR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: 15% increase, or 2,434 additional visits compared to baseline</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 6 (P-21):</strong></td>
<td>Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 7 (I-23):</strong></td>
<td>Increase specialty care clinic volume and improve access for patients seeking services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 (I-23,1):</td>
<td>Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (established in FY12).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Total number of visits for reporting period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Data Source: Registry, EHR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: 20% increase, or 3,245 additional visits compared to baseline</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 8 (P-21):</strong></td>
<td>Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Regional Healthcare Partnership Plan  
**Region 3**  
751

<table>
<thead>
<tr>
<th><strong>139135109.1.8</strong></th>
<th><strong>1.9.2</strong></th>
<th><strong>A-D</strong></th>
<th><strong>EXPAND SPECIALTY CARE CAPACITY DIABETES: ENDOCRINOLOGY PEDIATRIC CARE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Texas Children's Hospital</strong></td>
<td><strong>139135109.3.22</strong></td>
<td><strong>IT- 5.1</strong></td>
<td><strong>139135109</strong></td>
</tr>
<tr>
<td><strong>Improved cost savings</strong></td>
<td><strong>139135109.3.23</strong></td>
<td><strong>IT- 5.2</strong></td>
<td><strong>Per episode of care cost</strong></td>
</tr>
<tr>
<td><strong>Length of stay</strong></td>
<td><strong>139135109.3.24</strong></td>
<td><strong>IT- 5.3</strong></td>
<td><strong>Third Next Available Appointment</strong></td>
</tr>
<tr>
<td><strong>IT- 1.1</strong></td>
<td><strong>139135109.3.25</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</th>
<th><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</th>
<th><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</th>
<th><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Goal:** Participate in all semi-annual face-to-face meetings or seminars.  
**Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.  
Milestone 2 Estimated Incentive Payment: $1,074,372.50 | **Metric 1 (P-21.1):** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.  
**Goal:** Participate in all semi-annual face-to-face meetings or seminars.  
**Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.  
Milestone 4 Estimated Incentive Payment: $1,172,083 | **Metric 1 (P-21.1):** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.  
**Goal:** Participate in all semi-annual face-to-face meetings or seminars.  
**Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.  
Milestone 6 Estimated Incentive Payment: $1,175,490 | **Metric 1 (P-21.1):** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.  
**Goal:** Participate in all semi-annual face-to-face meetings or seminars.  
**Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.  
Milestone 8 Estimated Incentive Payment: $971,057 |
| **Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone):** $2,148,745 | **Year 3 Estimated Milestone Bundle Amount: $2,344,166** | **Year 4 Estimated Milestone Bundle Amount: $2,350,980** | **Year 5 Estimated Milestone Bundle Amount: $1,942,114** |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $8,786,005
Project Option 1.9.2- Expand Access to Specialty Care

**Unique RHP Project ID:** 139135109.1.9  
**Performing Provider Name/TPI:** Texas Children’s Hospital/ 139135109

**Project Summary:** This project will allow us to increase the number of children evaluated for abuse and neglect by a child abuse specialist by increasing clinic appointments and the number of providers.

**Provider:**
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966</td>
<td>Medicaid and CHIP- 53.6%</td>
<td>Hispanic-</td>
</tr>
<tr>
<td>Births (babies delivered)- 2,181</td>
<td>Commercial Insurance- 40.6%</td>
<td>African American-</td>
</tr>
<tr>
<td>Emergency visits-113,586</td>
<td>Self-Pay- 1.8%</td>
<td>Caucasian-</td>
</tr>
<tr>
<td>Outpatient visits- 3,066,765</td>
<td>Medicare- 1.2%</td>
<td>Asian-</td>
</tr>
</tbody>
</table>

**Need for the project:**
Child Maltreatment is the medical and psychological result of enormous social dysfunction in families. The system that strives to support or change this is based on improving and solidifying the social needs as well as the medical needs of these patients and their families and/or guardians. Providers with extensive training and experience in child maltreatment and family violence are a necessary component of this subspecialty.

**Target Population:**
All patients within the system who are suspected victims of child maltreatment may benefit from this project.

**Category 1 or 2 expected patient benefits:**
Our DY3 goal is to increase the percentage of patients evaluated for abuse and/or neglect by a child abuse pediatrician by 4% or 1245 patients. Our DY4 goal is to increase the percentage of patients evaluated for abuse and/or neglect by a child abuse pediatrician by 6% over baseline or 1269 patients. Our DY5 goal is to increase the percentage of patients evaluated for abuse and/or neglect by a child abuse pediatrician by 8% or 1294 patients.
Category 3 outcomes:
OD 10 Quality of life
IT-10.1 Improved quality of Life/Functional status
Project Option- 1.9.2 Improve access to specialty care: Expand Child Abuse Care

Unique Project ID: 139135109.1.9

Performing Provider Name/TPI: Texas Children’s Hospital/139135109

Project Description:
Texas Children’s Hospital proposes to establish a specialty care program for children who have experienced abuse or neglect.

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally. This project will allow us to increase the number of children evaluated for abuse and neglect by a child abuse specialists. Child Maltreatment is the medical and psychological result of enormous social dysfunction in families. The system that strives to support or change this is based on improving and solidifying the social needs as well as the medical needs of these patients and their families and/or guardians. Providers with extensive training and experience in child maltreatment and family violence are a necessary component of this subspecialty.¹

The patients evaluated by these providers are then connected with our nurse managers and social workers who act as patient navigators to help these high risk special needs children and families coordinate the care and services necessary to ensure the child’s health and safety. Our program provides for accurate diagnosis, treatment, follow-up and ongoing care for these high risk and vulnerable patients. Our follow-up clinic is unique in its focus, as a majority of these children are medically complex with special needs as a result of the abuse inflicted upon them.

Over 4,000 children live in foster homes in this area and in 2010 the number of CPS investigations in Harris County was 28,549. Six thousand five hundred and thirty-five children were confirmed victims of abuse or neglect and 44 of these cases resulted in child deaths. Expanding the focus to the entire southeast Texas region from which our patients originate, that number is doubled to over 12,000 confirmed cases of abuse or neglect.

In 2006 the American Board of Pediatrics certified pediatric child abuse as a subspecialty, in recognition of the growing and multifaceted need for accurate diagnosis of child maltreatment, working with the community in ensuring child safety, providing medical expertise to the legal system, and overseeing child abuse prevention programs. The number of children evaluated by

our physician specialists has steadily increased each year, totaling 1198 in 2012, which accounts for only 50% of all our child abuse evaluations. Due to the limited number of providers, many patients evaluated for child maltreatment are not seen by child abuse specialists. In most of these cases they are evaluated by non-child abuse specialists in an emergency center rather than a more appropriate clinic environment. Currently clinic appointments for physical abuse and neglect are only available 2 half days a week, and for sexual abuse only 4 days a week resulting in the use of an emergency center when the outpatient facilities are unavailable or at capacity.

Goals and Relationship to Regional Goals:

Project Goals:

To meet the growing demand for high impact pediatric child abuse services, TCH will:

- Focus on provider productivity to optimize clinical time for all providers,
- Expand internal capacity by offering a child abuse fellowship to staff an additional clinic day and adding additional providers to evaluate patients and mentor fellowship level learners.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients’ needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges:

In Texas, limited Medicaid reimbursement is an ongoing challenge for children’s hospitals and the workforce that provides health care services for the pediatric population enrolled in this program, especially for the child victim population. As advocates for improving and sustaining quality children’s health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded. Without additional funding provider by this project we have limited child abuse specialists, resulting in some children being evaluated in an emergency center by an emergency medicine physician rather than a child abuse specialist. In addition, many of our patients have long term consequences of maltreatment and it is important that their follow up care coordinated.

We anticipate difficulty in adding providers as the market for board certified or board eligible child abuse pediatricians is limited due to the newness of the specialty. Our child abuse

fellowship program has been available since July 2012 and we have yet to fill our fellowship position in spite of vigorous recruitment efforts. With the assistance of our marketing team, a TCH Child Abuse Pediatrics fellowship news release was distributed on the wire on June 20, 2012, and was picked up by 252 placements. The news was highlighted in numerous national outlets, key competitive markets and local/regional outlets. The release was even picked up by international media including outlets in Japan, China, Germany, India, Philippines and Guam. In addition, recruitment for a pediatric nurse practitioner for the Child Abuse Pediatrics program has proven difficult to fill. After several months of recruiting, we hired a NP in August of last year only to lose her after a little more that a year in the position. The training time for both a fellow and a nurse practitioner is at least one year before they are ready to function independently in the realm of child abuse.

Five year expected outcome for provider and patients:
Texas Children’s Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline: Number of children evaluated for abuse and neglect by a child abuse specialists in FY 12. 338 children were evaluated by a child abuse specialists in our physical abuse clinic in FY 12 and 860 children in our sexual abuse clinic. Our fiscal year runs from October 1st to September 30th.

Rationale:
Houston is one of the fastest growing communities with a Harris County total population of 4,092,459 according to 2010 US Census Bureau data, with almost 1.3 million under the age of 20 years. Re-designing medical specialty clinics in order to shorten appointment cycle time and maximize provider productivity allows the most efficient utilization of specialty provider resources. The number of physical abuse and neglect cases evaluated by our child abuse specialists has steadily increased each year, totaling 1198 (49.7% of all abuse evaluations). Our project significantly enhances TCH’s existing child abuse services. Child Abuse Pediatrics is subspecialty that has been identified at both at the national and state levels to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012).

In many cases throughout the Houston area and throughout the southeast Texas region, children at risk or suspected to be victims of child abuse are often seen by general pediatricians, emergency medicine physicians or family practitioners due to availability of child abuse pediatricians. In the current state of our program we struggle to meet the needs of this patient population with only 2 dedicated physician specialists and the clinical demands of an inpatient consult service and 2 outpatient clinics as well as the additional community responsibilities of court appearances, outreach education, clinical research and directing prevention programs. This funding will allow our program to increase the availability of child abuse specialists for hospital consultations, clinic appointments for evaluations as well as for longer term follow-up care.
**Project Components:** Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics relate to project components.

a. Conduct specialty care gap assessment based on community need for subspecialty.
b. Implement transparent standardized referrals across the system
c. Increase specialty care volume of visits and evidence of improved access for patients seeking services
d. Increase service availability hours and increase number of specialty clinic locations.
e. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges. It is our goal to reach the industry standard of less than 14 days for the 3rd available appointment.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.³

**Milestones and Metrics**
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-21 (P-21.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

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

- CN.2: Inadequate access to specialty care,
- CN.6: Inadequate access to treatment and services designed for children.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
At present, the TCH child abuse pediatricians are a valuable part of the medical team in the time of a child’s acute illness precipitated by child abuse or neglect in the cases of the most severely injured or neglected victims. Those children who may have suffered less grievous injury or had abusive injury go unrecognized by other subspecialists are not currently accommodated with our limited clinic infrastructure. An established system designed for the unique needs of this patient population, to address injury detection and repair, and also to bridge the gap for ongoing health needs while children are in foster care and will be most beneficial for the children and families, and can only be accomplished by increasing physician staffing and clinic resources⁴.

---


⁴ Lane WG, Dubowitz H. Primary care pediatricians’ experience, comfort and competence in the evaluation and management of child maltreatment: Do we need child abuse experts? *Child Abuse & Neglect* 33 (2009) 76–83

Related Category 3 Outcome Measure(s):
OD-10 Quality of Life
The outcome for our project will increase the number of patients evaluated by a child abuse specialist by 4% in year 3, 6% in year 4 and 8% in year 5 as result of increased providers and clinic resources and improved efficiency in program processes as well as improve the quality of life for the patients seen. Many children are evaluated in the emergency center setting without the clinical expertise of a child abuse specialist. With additional providers, the expansion of clinic availability and improved processes, patients who do not clinically meet the criteria for the emergency setting would be evaluated in the clinic by a child abuse specialist. As a result of the evaluation and intervention by the physician and supporting team in the clinic, the health, safety and social well-being of the child is enhanced.

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.  

Relationship to other Projects: All of Texas Children’s projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

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

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

Project Valuation: This project’s value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.  

---


includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1</strong> [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from</td>
<td><strong>Metric 1</strong> (I-23.1): Documentation of increased number of evaluations with a child abuse specialist. Demonstrate improvement over prior reporting period (baseline established in FY12). Goal: 4% increase (1245 patients) a. Total number of visits for reporting period</td>
<td><strong>Metric 3</strong> (I-23): Increase specialty care evaluation visits and evidence of improved access for patients seeking services. <strong>Metric 1</strong> (I-23.1): Documentation of increased number of evaluations with a child abuse specialist. Demonstrate improvement over prior reporting period (baseline established in FY12). Goal: 4% increase (1245 patients) a. Total number of visits for reporting period</td>
<td><strong>Metric 3</strong> (I-23): Increase specialty care evaluation visits and evidence of improved access for patients seeking services. <strong>Metric 1</strong> (I-23.1): Documentation of increased number of evaluations with a child abuse specialist. Demonstrate improvement over prior reporting period (baseline established in FY12). Goal: 4% increase (1245 patients) a. Total number of visits for reporting period</td>
<td><strong>Metric 3</strong> (I-23): Increase specialty care evaluation visits and evidence of improved access for patients seeking services. <strong>Metric 1</strong> (I-23.1): Documentation of increased number of evaluations with a child abuse specialist. Demonstrate improvement over prior reporting period (baseline established in FY12). Goal: 4% increase (1245 patients) a. Total number of visits for reporting period</td>
<td><strong>Metric 3</strong> (I-23): Increase specialty care evaluation visits and evidence of improved access for patients seeking services. <strong>Metric 1</strong> (I-23.1): Documentation of increased number of evaluations with a child abuse specialist. Demonstrate improvement over prior reporting period (baseline established in FY12). Goal: 4% increase (1245 patients) a. Total number of visits for reporting period</td>
</tr>
<tr>
<td><strong>Milestone 1</strong> (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care</td>
<td><strong>Milestone 1 Estimated Incentive Payment:</strong> $250,307.50</td>
<td><strong>Milestone 3 Estimated Incentive Payment:</strong> $273,072</td>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $273,865.50</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $226,237</td>
<td><strong>Milestone 8 Estimated Incentive Payment:</strong> $224,237</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> (P-21): Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td><strong>Milestone 2 Estimated Incentive Payment:</strong> $293,821.00</td>
<td><strong>Milestone 4 Estimated Incentive Payment:</strong> $293,821.00</td>
<td><strong>Milestone 6 Estimated Incentive Payment:</strong> $293,821.00</td>
<td><strong>Milestone 8 Estimated Incentive Payment:</strong> $293,821.00</td>
<td><strong>Milestone 9 Estimated Incentive Payment:</strong> $293,821.00</td>
</tr>
<tr>
<td><strong>Milestone 3</strong> (I-23): Increase specialty care evaluation visits and evidence of improved access for patients seeking services. <strong>Metric 1</strong> (I-23.1): Documentation of increased number of evaluations with a child abuse specialist. Demonstrate improvement over prior reporting period (baseline established in FY12). Goal: 4% increase (1245 patients) a. Total number of visits for reporting period b. Data Source: EPIC Electronic Medical Record; Child Abuse Database/Registry</td>
<td><strong>Milestone 3 Estimated Incentive Payment:</strong> $273,072</td>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $273,865.50</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $226,237</td>
<td><strong>Milestone 9 Estimated Incentive Payment:</strong> $224,237</td>
<td><strong>Milestone 10 Estimated Incentive Payment:</strong> $224,237</td>
</tr>
<tr>
<td><strong>Milestone 4</strong> (P-21): Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td><strong>Milestone 4 Estimated Incentive Payment:</strong> $293,821.00</td>
<td><strong>Milestone 6 Estimated Incentive Payment:</strong> $293,821.00</td>
<td><strong>Milestone 8 Estimated Incentive Payment:</strong> $293,821.00</td>
<td><strong>Milestone 10 Estimated Incentive Payment:</strong> $293,821.00</td>
<td><strong>Milestone 11 Estimated Incentive Payment:</strong> $293,821.00</td>
</tr>
<tr>
<td><strong>Milestone 5</strong> (I-23): Increase specialty care evaluation visits and evidence of improved access for patients seeking services. <strong>Metric 1</strong> (I-23.1): Documentation of increased number of evaluations with a child abuse specialist. Demonstrate improvement over prior reporting period (baseline established in FY12). Goal: 4% increase (1245 patients) a. Total number of visits for reporting period b. Data Source: Child Abuse Database/Registry, EHR</td>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $273,865.50</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $226,237</td>
<td><strong>Milestone 9 Estimated Incentive Payment:</strong> $224,237</td>
<td><strong>Milestone 11 Estimated Incentive Payment:</strong> $224,237</td>
<td><strong>Milestone 12 Estimated Incentive Payment:</strong> $224,237</td>
</tr>
<tr>
<td><strong>Milestone 6</strong> (P-21): Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td><strong>Milestone 6 Estimated Incentive Payment:</strong> $293,821.00</td>
<td><strong>Milestone 8 Estimated Incentive Payment:</strong> $293,821.00</td>
<td><strong>Milestone 10 Estimated Incentive Payment:</strong> $293,821.00</td>
<td><strong>Milestone 12 Estimated Incentive Payment:</strong> $293,821.00</td>
<td><strong>Milestone 13 Estimated Incentive Payment:</strong> $293,821.00</td>
</tr>
<tr>
<td><strong>Milestone 7</strong> (I-23): Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. <strong>Metric 1</strong> (I-23.1): Documentation of increased number of evaluations with a child abuse specialist. Demonstrate improvement over prior reporting period (baseline established in FY12). Goal: 8% increase (1294 patients) a. Total number of evaluations for reporting period b. Data Source: Child Abuse Database/Registry, EHR</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $226,237</td>
<td><strong>Milestone 9 Estimated Incentive Payment:</strong> $224,237</td>
<td><strong>Milestone 11 Estimated Incentive Payment:</strong> $224,237</td>
<td><strong>Milestone 13 Estimated Incentive Payment:</strong> $224,237</td>
<td><strong>Milestone 14 Estimated Incentive Payment:</strong> $224,237</td>
</tr>
<tr>
<td><strong>Milestone 8</strong> [P-21]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td><strong>Milestone 8 Estimated Incentive Payment:</strong> $293,821.00</td>
<td><strong>Milestone 10 Estimated Incentive Payment:</strong> $293,821.00</td>
<td><strong>Milestone 12 Estimated Incentive Payment:</strong> $293,821.00</td>
<td><strong>Milestone 14 Estimated Incentive Payment:</strong> $293,821.00</td>
<td><strong>Milestone 15 Estimated Incentive Payment:</strong> $293,821.00</td>
</tr>
<tr>
<td>Related Category 3</td>
<td>Outcome Measure(s):</td>
<td>Quality of Life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------</td>
<td>----------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>139135109.1.9</strong></td>
<td><strong>1.9.2</strong></td>
<td><strong>A-D</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Texas Children’s Hospital</strong></td>
<td><strong>EXPAND SPECIALTY ACCESS TO CHILD ABUSE SPECIALISTS</strong></td>
<td>139135109</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Year 2 (10/1/2012 – 9/30/2013)
- Semi-annual face-to-face meetings or seminars organized by the RHP.
- Goal: Participate in all semi-annual face-to-face meetings or seminars.
- Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.
- Milestone 2 Estimated Incentive Payment: $250,307.50

Year 3 (10/1/2013 – 9/30/2014)
- Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.
- Goal: Participate in all semi-annual face-to-face meetings or seminars.
- Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.
- Milestone 4 Estimated Incentive Payment: $273,072

Year 4 (10/1/2014 – 9/30/2015)
- Metric 6 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.
- Goal: Participate in all semi-annual face-to-face meetings or seminars.
- Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.
- Milestone 8 Estimated Incentive Payment: $226,237

Year 5 (10/1/2015 – 9/30/2016)
- Milestone 6 Estimated Incentive Payment: $273,865.50

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $500,615
**Year 3 Estimated Milestone Bundle Amount:** $546,144
**Year 4 Estimated Milestone Bundle Amount:** $547,731
**Year 5 Estimated Milestone Bundle Amount:** $452,474

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $2,046,964
Project Option 1.9.2- Expand Access to Specialty Care

Unique RHP Project ID: 139135109.1.10
Performing Provider Name/TPI: Texas Children’s Hospital/ 139135109

Project Summary:
The Meyer Center for Developmental Pediatrics works with children with suspected motor, cognitive, language, and/or social-emotional developmental delays, suspected developmental disabilities, and children at risk for developmental-behavioral disorders. This project will build the volume of services provided in developmental-behavioral health in order to better serve the high demand for these children.

Provider:
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966</td>
<td>Medicaid and CHIP- 53.6%</td>
<td>Hispanic-</td>
</tr>
<tr>
<td>Births (babies delivered)-</td>
<td>Commercial Insurance- 40.6%</td>
<td>African American-</td>
</tr>
<tr>
<td>2,181</td>
<td>Self-Pay- 1.8%</td>
<td>Caucasian-</td>
</tr>
<tr>
<td>Emergency visits-113,586</td>
<td>Medicare- 1.2%</td>
<td>Asian-</td>
</tr>
<tr>
<td>Outpatient visits- 3,066,765</td>
<td></td>
<td>Other-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>American Indian-</td>
</tr>
</tbody>
</table>

Intervention(s):
Interventions include expanding the training of subspecialists, expanding the role of a referral center to better allocate children with different needs to a provider that can best suit their needs, refine the role of a Primary Care Pediatrician to help provide long term care, and expanding internal provider capacity and hiring additional clinical providers.

Need for the project:
Developmental-behavioral disorders are by far the most common chronic problems faced in primary care pediatric practice, yet there is a severe shortage of fellowship trained subspecialists. In the United States, approximately 1 in 5 children have a condition that our specialists help treat.

Target Population:
The providers in the Meyer Center work with children with suspected motor, cognitive, language, and/or social-emotional developmental delays, children with suspected developmental disabilities, and children at risk for developmental-behavioral disorders.

Category 1 or 2 expected patient benefits:
Our DY3 goal is to improve upon DY2 baseline of patient volume by 3% or 59 additional visits compared to baseline. Our DY4 goal is for 6% of patients’ volume increase or 119 additional
visits compared to baseline. Our DY5 goal is to improve upon DY2 baseline of patient volume by 9% or 178 additional visits compared to baseline.

**Category 3 outcomes:**
Outcome Domain 10 – Quality of Life/Functional Status
IT-10.1 Quality of Life
Project Option: 1.9.2 Expand Access to Specialty Care: Developmental Pediatrics

Unique Project ID: 139135109.1.10
Performing Provider Name/ TPI: Texas Children’s Hospital/ 139135109

Project Description:
Texas Children’s Hospital will increase capacity in the Developmental Pediatrics Clinic.

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Specifically this project will increase capacity in our Developmental Pediatrics Clinic. Developmental Pediatrics and Behavioral Medicine are identified subspecialties, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). The Meyer Center for Developmental Pediatrics consists of 9 Developmental Pediatricians, 1 Social Worker, 1 Nurse Practitioner, 1 Neuropsychologist and 1 Licensed Professional Counselor. This service is among the largest in the country to provide medically-based diagnostic services and longitudinal care to children with developmental-behavioral concerns. The providers in the Meyer Center work with children with suspected motor, cognitive, language, and/or social-emotional developmental delays, children with suspected developmental disabilities (learning disabilities, intellectual disabilities, AD/HD, autism spectrum disorders, cerebral palsy, spina bifida, vision impairments, hearing impairments), and children at risk for developmental-behavioral disorders (former premature infants and high risk term infants; children with congenital anomalies or genetic syndromes, such as Down syndrome or Fragile X syndrome). In the United States, approximately 1 in 5 children have a condition that our specialists help treat.

The most significant challenge in the field of developmental-behavioral pediatrics is that developmental-behavioral disorders are by far the most common chronic problems faced in primary care pediatric practice, yet there is a severe shortage of fellowship trained subspecialists to whom primary care pediatricians can refer their patients. Despite developmental-behavioral disorders affecting approximately 20% of children, less than 1% of board-certified pediatricians are subspecialty-certified in either Neurodevelopmental Disabilities or Developmental-Behavioral Pediatrics. Thus, a most critical mission of the Meyer Center remains educating pediatric residents, subspecialty fellows, and pediatric health care professionals in practice. Of nearly 200 pediatric training programs in the country, since 2003, the Meyer Center has been one of only 8 programs nationally to provide residency training in Neurodevelopmental Disabilities. In 2011, the Meyer Center was approved by the Accreditation Council of Graduate Medical
Education to begin a new fellowship program in Developmental-Behavioral Pediatrics (one of only 35 programs nationally). This makes Texas Children’s Hospital one of only two hospitals nationally to house accredited training programs in both Neurodevelopmental Disabilities and Developmental-Behavioral Pediatrics and the only one in the nation to have both of these programs led within a single Section of Developmental Pediatrics. In 2011, Meyer Center faculty also obtained grant funding to develop a new competency-based curriculum in developmental pediatrics to provide pediatric residents longitudinal training in developmental-behavioral pediatrics across their three years of residency, so that they will be equipped to identify and manage children with developmental and behavioral concerns in their future practices. Finally, Meyer Center faculty have continued to actively present at local, regional, national, and international continuing medical education venues to provide in-service developmental-behavioral education to pediatric health care professionals in practice.

Within the last three to five years, the referral triage mechanism for the Behavioral and Developmental Sciences at Texas Children’s Hospital (TCH), which includes the Meyer Center for Developmental Pediatrics, has been somewhat loose, and tracking has been inconsistent. With the introduction of the Behavioral and Developmental Sciences Referral Center in 2011, which serves as a central portal for the receipt and tracking of all behavioral and developmental sciences clinical service requests, a clear understanding of the demand for service in Developmental Pediatrics has been established. Given the frequency of children impacted by conditions that the Meyer Center specialists treat (1 in 5 children in the United States), the wait time for a new patient appointment in this service line has been as high as 36 months. The Referral Center allows TCH to examine specific needs of patients asking for services through the Behavioral and Developmental Sciences. In the past, these referrals may have gone just to one service line. Now, the Referral Center can look to see if other behavioral specialists, like a Psychiatrist, Psychologist or a specialist through the Autism Center may serve the patient’s needs. With this model, TCH can look sometimes match patients with alternate providers to meet their needs rather than wait the significant wait time for services specifically within Developmental Pediatrics. Looking at Behavioral and Developmental Sciences across service lines also allows TCH to monitor closely wait times across service areas (not just Developmental Pediatrics, but also Autism) work through leadership to shift provider resources or to clearly outline recruitment needs.

**Goals and Relationship to Regional Goals:**

**Project Goals:** To meet the growing demand for specialized pediatric services TCH will:

1. Focus on provider productivity to optimize clinical time for all providers and enhance training of subspecialists and fellows.
2. Expand the role of the Behavioral and Developmental Referral Center to refine algorithms to triage patients to the most appropriate providers based on patient need and provider availability to ensure that only the most appropriate patients for a Developmental Pediatrics evaluation are routed to this service line, thereby increasing the availability for new patient appointments of these targeted providers.
3. Refine new clinical care model to expand the role of the Primary Care Pediatrician so as to reduce the need for return patient appointments, increasing the availability for new patient appointments by current providers.
4. Expand internal capacity by hiring additional clinical providers.
5. Enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve the five additional community locations for specialty care.
6. Optimize clinical care through the use of social workers to reach out to families as they wait for formal medical assessments through our services.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients’ needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Challenges:
In Texas, limited Medicaid reimbursement is an ongoing challenge for children’s hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. In Behavioral and Developmental Health, reimbursement is particularly challenging. Certain testing codes cannot be used on the same date as some medical codes, which forces TCH practices to choose between what is best for patient care in terms of convenience for families (to have all procedures performed on the same visit date so that parking, commuting, time off from work and other personal expenses related to the visit can be limited) or asking the patient to come in multiple times so that services can be billed in a manner that can be fully reimbursed. As advocates for improving and sustaining quality children’s health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded.

TCH continues to increase our overall volumes at all of our locations by 5.7% year over year in our pediatric physician practices. In Developmental Pediatrics specifically, over the last year, the Service has been able to reduce wait time by 64% from its peak wait time of 36 months. However, there is still a significant amount of work that needs to be done to improve access to services in Developmental Pediatrics. By reconfiguring clinic processes, scheduling, and the addition of more providers (including maximizing clinical support like social workers and other mid-level providers to the top of their license), we will try to improve this measure.

Five year expected outcome for provider and patients:
Texas Children’s Hospital expects to see an increase in the volume of patients who are able to access subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:
The baseline for patient volumes in FY 12 is 1,977. TCH fiscal year is from October 1st to September 30th.

**Rationale:**

The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH’s existing developmental pediatric services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time.

For children, especially those with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home. Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. Increasing pediatric population and continued lack of pediatric subspecialists due to the inequity in reimbursement between Medicaid and Medicare is an ongoing problem for children’s hospitals and the pediatric health care workforce.

**Project Components:**
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

a. Conduct specialty care gap assessment based on community need for subspecialty.

b. Implement transparent standardized referrals across the system

c. Increase specialty care volume of visits and evidence of improved access for patients seeking services

d. Increase service availability hours and increase number of specialty clinic locations.

e. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.\(^1\)

**Milestones and Metrics**
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-21 (P-21.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

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

- CN2: Inadequate access to specialty care

---

• CN6: Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
As stated throughout this proposal, the special needs of children with developmental disabilities or delays are significant. This project will allow Texas Children’s to significantly enhance our existing Neurosurgery appointment availability. With the shortage of specialists in this area, TCH has had work within the resources available nationwide to build a program that provides superior care for children with these conditions. This project, by focusing not only on national recruitment of the limited number of developmental pediatricians, but also focusing on the use of mid-level providers for care, aims at improving access to these services for children in the state of Texas.

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

**Reasons/rationale for selecting the outcome measures:**
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs. Additionally, increased access to care leads to faster evaluation and treatment which will lead to an improved quality of life for the children. This project will allow us to not only increase access to medical care for these children, but also community resources coordinated by our social work team.

**Relationship to other Projects:** All of Texas Children’s projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

**Plan for Learning Collaborative:** We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects

---

will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region’s health care system.

**Project Valuation:** This project’s value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation also includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---


**Related Category 3 Outcome Measure(s):** 139135109.1.10

| Metric 1 P-1.1 | Documentation of gap assessment  
| Data Source: Gap Assessment  
| Milestone 1 Estimated Incentive Payment: $416,570.50 |

**Milestone 1 (P-1):** Conduct specialty care gap assessment to determine barriers to accessing subspecialty care.

**Milestone 2 (P-21):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

**Metric 1 [P-21.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Goal:** Participate in all semi-annual face-to-face meetings or seminars.

**Year 2 (10/1/2012 – 9/30/2013):** Participate in all semi-annual face-to-face meetings or seminars organized by the RHP. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

**Year 3 (10/1/2013 – 9/30/2014):** Participate in all semi-annual face-to-face meetings or seminars organized by the RHP. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

**Year 4 (10/1/2014 – 9/30/2015):** Participate in all semi-annual face-to-face meetings or seminars organized by the RHP. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

**Year 5 (10/1/2015 – 9/30/2016):** Participate in all semi-annual face-to-face meetings or seminars organized by the RHP. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>139135109.3.26</th>
<th>IT- 10.1</th>
<th>Quality of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $416,570.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Participate in all semi-annual face-to-face meetings or seminars.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment: $454,456</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $833,141</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider should publicly commit to implementing these improvements.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Participate in all semi-annual face-to-face meetings or seminars.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 6 Estimated Incentive Payment: $455,777</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $833,141</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider should publicly commit to implementing these improvements.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Participate in all semi-annual face-to-face meetings or seminars.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 8 Estimated Incentive Payment: $376,511.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3 Estimated Milestone Bundle Amount: $908,912</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4 Estimated Milestone Bundle Amount: $911,554</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5 Estimated Milestone Bundle Amount: $753,023</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add milestone bundle amounts over Years 2-5): 3,406,630</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Project Option 1.9.2- Expand Access to Specialty Care

**Unique RHP Project ID:** 139135109.1.11  
**Performing Provider Name/TPI:** Texas Children’s Hospital/ 139135109

**Project Summary:** Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with allergy, asthma, primary immunodeficiency and secondary immunodeficiency.

**Provider:**  
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765</td>
<td>Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%</td>
<td>Hispanic- African American- Caucasian- Asian- Other- American Indian-</td>
</tr>
</tbody>
</table>

**Volume Statistics**

- Hospital Admissions: 25,966
- Births (babies delivered): 2,181
- Emergency Visits: 113,586
- Outpatient Visits: 3,066,765

**Intervention(s):**

Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with allergy, asthma, primary immunodeficiency and secondary immunodeficiency.

**Need for the project:**

The number of children referred into the TCH Allergy/Immunology clinic has increased by over 40% from 2010 to 2012 and subsequently is unable to meet the continually increasing demand.

**Target Population:**

Our target population is patients seeking the full spectrum of services from general allergy and immunology care to specialized treatment for Severe Combined Immunodeficiency Disorder and patients that are at risk for anaphylaxis. One particular area of focus is the diagnosis and care management of food allergies in the pediatric population.

**Category 1 or 2 expected patient benefits:**

I-23.1: Our goal is to increase the number of visits by 10% in DY3 or 305 additional visits compared to baseline, by 15% in DY4, or 458 additional visits compared to baseline, and by 20% in DY5 or 610 additional visits compared to baseline.

**Category 3 outcomes:**
IT-5 Improving cost of care
IT 5.2: Per Episode Cost of Care
IT 5.3: Other Outcome Improvement Target: Reduced Length of Stay
IT-1.1: Third Next Available Appointment
Project Option- 1.9.2 Improve access to specialty care: Expand Pediatric Allergy/Immunology Care

Unique Project ID: 139135109.1.11

Performing Provider and TPI: Texas Children’s Hospital/ 139135109

Project Description:
*Texas Children’s Hospital proposes to expand access to care in the Allergy/Immunology clinic in order to meet increased demand for care and reduce appointment wait time.*

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

The TCH Allergy & Immunology (A&I) Service treats patients with allergy, asthma, primary immunodeficiency and secondary immunodeficiency and provides a variety of research and treatment options for infants, children and adolescents with immunodeficiency. TCH Allergy & Immunology Service also operates a full-function lab that examines cell function and surface markers that screen for and monitor immune deficiencies such as Severe Combined Immunodeficiency Disorder (SCID). The proposed project seeks to increase access for children to pediatric subspecialty services in the A&I clinic at Texas Children’s Hospital. The number of children referred into the TCH Allergy/Immunology clinic has increased significantly from a monthly average of 185 in 2010 to a monthly average of 260 in 2012. One particular area of focus of the TCH A&I clinic is the diagnosis and care management of food allergies in the pediatric population. According to the Center for Disease Control and Prevention, there has been an 18% increase in food allergies among school-aged children from 1997 to 2007. Between 1 in 13 and 1 in 25 are now affected, with 40% reporting a severe reaction (Texas Department of State Health Services – “Guidelines for the Care of Students With Food Allergies At-Risk for Anaphylaxis: To Implement Senate Bill 27 (82nd Legislative Session)”).

Goals and Relationship to Regional Goals:

Project Goals:

To meet the growing demand for specialized pediatric services, TCH will enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve 1-3 additional community locations for allergy & immunology specialty clinics and on provider productivity to optimize clinical time for all providers and enhance training of subspecialists and fellows by:
1. Focusing on provider productivity to optimize clinical time for all providers
2. Establishing an initiative to review scheduling processes to increase the availability of these targeted providers
3. Expanding internal capacity by hiring additional clinical providers
4. Enhancing service availability by targeting new providers to not only work in the Texas Medical Center but to also serve 1-3 additional community locations for allergy and immunology care

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients’ needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges:
In Texas, limited Medicaid reimbursement is an ongoing challenge for children’s hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children’s health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of the waiver to ensure existing programs and services will be maintained and expanded.

Five year expected outcome for provider and patients:
Texas Children’s Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:
The baseline for patient volumes in fiscal year 2012 is 3,050. Our fiscal year runs from October 1st through September 30th.

Rationale:
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH’s existing allergy & immunology services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. Specifically, we will provide comprehensive care for children within focused specialty programs such as: allergy, asthma, primary immunodeficiency and secondary immunodeficiency.
Increasing pediatric population and continued lack of pediatric subspecialists due to the inequity in reimbursement between Medicaid and Medicare is an ongoing problem for children’s hospitals and the pediatric health care workforce.

**Project Components:**
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

- a. Conduct specialty care gap assessment based on community need for subspecialty
- b. Implement transparent standardized referrals across the system
- c. Increase specialty care volume of visits and evidence of improved access for patients seeking services
- d. Increase the number of specialty clinic locations
- e. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.¹

**Milestones and Metrics**
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-21 (P-21.1);
- Improvement milestones and metrics: I-23 (I-23.1)

**Unique community need identification number the project addresses:**
- CN.2: Inadequate access to specialty care,
- CN.6: Inadequate access to treatment and services designed for children.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This project will enhance current services by expanding and maximizing provider accessibility that will result in a greater number of patients served. In addition it will result in prompt service and allow more children access to allergy & immunology subspecialty care.

**Related Category 3 Outcome Measure(s):**
OD-5 Cost of Care
IT-5.1: Improved cost savings
IT-5.2: Per episode of care cost
IT-5.3: Length of stay

OD-1 Primary Care and Chronic Disease Management

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs. Because of the continued growth in demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The Affordable Care Act focused on the triple aim – improving quality, reducing costs and improving access. This project strives t meet those same goals. We agree that increased access should be coupled with contrilling unnecessary costs.

Relationship to other Projects: All of Texas Children’s projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

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

Project Valuation: This project’s value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation also includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though

---

we know the patient’s quality of life will be improved for many years. We recognize that this is a
government funded waiver and thus we chose to have conservative valuations out of respect for
the taxpayer funded program.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>IMPROVE ACCESS TO SPECIALTY CARE: EXPAND PEDIATRIC ALLERGY/IMMUNOLOGY CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>139135109.1.11</td>
<td>I.9.2 A-D</td>
<td>Improved cost savings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Per episode of care cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Length of stay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Third Next Available Appointment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Texas Children’s Hospital</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 1 (P-1):</th>
<th>Conduct specialty care gap assessment to determine barriers to accessing subspecialty care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 (P-1.1):</td>
<td>Documentation of gap assessment Data Source: Gap Assessment</td>
</tr>
<tr>
<td></td>
<td>Milestone 1 Estimated Incentive Payment: $463,265.50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 2 (P-21):</th>
<th>Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 (P-21.1):</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Milestone 3 (I-23):</th>
<th>Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 (I-23.1):</td>
<td>Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (established in FY12).</td>
</tr>
<tr>
<td></td>
<td>a. Total number of visits for reporting period</td>
</tr>
<tr>
<td></td>
<td>b. Data Source: Registry, EHR Goal: 10% increase, or 305 additional visits compared to baseline</td>
</tr>
<tr>
<td></td>
<td>Milestone 3 Estimated Incentive Payment:$505,937.50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 4 (P-21):</th>
<th>Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 (P-21.1):</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 5 (I-23):</th>
<th>Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 (I-23.1):</td>
<td>Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (baseline established in FY12).</td>
</tr>
<tr>
<td></td>
<td>a. Total number of visits for reporting period</td>
</tr>
<tr>
<td></td>
<td>b. Data Source: EPIC medical record Goal: 15% increase, or 458 additional visits compared to baseline</td>
</tr>
<tr>
<td></td>
<td>Milestone 5 Estimated Incentive Payment:$506,867</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 6 (P-21):</th>
<th>Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 (P-21.1):</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 7 (I-23):</th>
<th>Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 (I-23.1):</td>
<td>Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (baseline established in FY12).</td>
</tr>
<tr>
<td></td>
<td>a. Total number of visits for reporting period</td>
</tr>
<tr>
<td></td>
<td>b. Data Source: EPIC medical record Goal: 20% increase, or 610 additional visits compared to baseline</td>
</tr>
<tr>
<td></td>
<td>Milestone 7 Estimated Incentive Payment: $418,716</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 8 (P-21):</th>
<th>Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 (P-21.1):</td>
<td></td>
</tr>
</tbody>
</table>
**Improve Access to Specialty Care: Expand Pediatric Allergy/Immunology Care**

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Improves access to specialty care: Expand pediatric allergy/immunology care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Texas Children’s Hospital**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Participate in semi-annual face-to-face meetings or seminars organized by the RHP.**

**Goal:** Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

**Milestone 2 Estimated Incentive Payment:** $463,265.50

<table>
<thead>
<tr>
<th>Metric 1 (P-21.1):</th>
<th>Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</th>
</tr>
</thead>
</table>

| Year 3 Estimated Milestone Bundle Amount: | $1,010,795 |
| Year 4 Estimated Milestone Bundle Amount: | $1,013,734 |
| Year 5 Estimated Milestone Bundle Amount: | $837,432 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $3,788,492
Project Option 1.9.2- Expand Access to Specialty Care

**Unique RHP Project ID:** 139135109.1.12  
**Performing Provider Name/TPI:** Texas Children’s Hospital/ 139135109

**Project Summary:** Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with hearing loss to sinus disease and swallowing abnormalities and those patients with disorders of the ear, nose and/or throat.

**Provider:**  
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765</td>
<td>Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%</td>
<td>Hispanic- African American- Caucasian- Asian- Other- American Indian-</td>
</tr>
</tbody>
</table>

**Intervention(s):** The division is establishing a Voice and Swallowing clinic to evaluate, diagnose, and treat complex disorders in swallowing and vocalization.

**Need for the project:** In 2012, referrals into the TCH Otolaryngology clinic averaged 900 per month. Given the increasing demand for these specialized services for the majority for FY10 and FY11, the average 3rd Available appointment was less than 30 days. Over the last 6 months of 2012, at our Texas Medical Center site and other community locations (except our West Campus clinic) exceed 30 days.

**Target Population:** Our target population is pediatric patients seeking the full spectrum of services from general otolaryngology services, patients with hearing loss, swallowing and vocalization disorders, cochlear implants, aerodigestive diseases, and those patients with disorders of the ear, nose and/or throat.

**Category 1 or 2 expected patient benefits:**
I-23.1: Our goal is to increase the number of visits by 3% in DY3 which is 548 additional visits across all locations of care compared to baseline, by 3% in DY4 which is 1,112 additional visits compared to baseline, and by 6% in DY5 which is 1,692 additional visits compared to baseline established in DY2.

**Category 3 outcomes:**
IT-5 Improving Cost of Care
IT 5.2: Per Episode Cost of Care
IT 5.3: Other Outcome Improvement Target: Reduced Length of Stay

OD 1- Primary Care and Chronic Disease Management
IT-1.1: Third Next Available Appointment
Project Option- 1.9.2 Expand Access to Specialty Care: Otolaryngology Pediatric Care

Unique Project ID: 139135109.1.12

Performing Provider Name/TPI: Texas Children’s Hospital/ 139135109

Project Description:

*Texas Children’s Hospital proposes to expand access to pediatric Otolaryngology care through the establishment of a Voice and Swallowing clinic to diagnose and treat complex disorders related to swallowing and vocalization.*

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation’s largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Our project proposal will significantly improve access to pediatric subspecialty care. The Texas Children’s (“TCH”) Pediatric Otolaryngology Division provides diagnoses and treatment for conditions from hearing loss to sinus disease and swallowing abnormalities. The Otolaryngology Division is establishing a Voice and Swallowing Clinic to evaluate diagnose and treat complex disorders in swallowing and vocalization. The Otolaryngology Division established the Aerodigestive Disease Clinic in 2011 and added the first laryngologist to practice at Texas Children’s Hospital, one of only three pediatric fellowship-trained voice specialists in the nation. We also began offering laryngealstroboscopy, an innovative way of looking at vibratory characteristics of the vocal chord. The Aerodigestive clinic is a multidisciplinary clinic with the pulmonary and gastroenterology sources for complex patients in participation in the Down Syndrome Clinic for specialized expertise with this patient population.

To help improve the diagnosis and treatment of children and babies with disorders of the ear, nose or throat, our physicians are involved in research projects concerning hearing, cochlear implantation, sleep apnea, neck masses and vocal fold mobility. In addition, we are participating in a National Institutes of Health (NIH) grant to study cochlear implants in children with multiple disabilities as well as a Texas Children’s Hospital-funded study of sleep apnea in children. In 2012, referrals into the TCH Otolaryngology clinic averaged 900 per month. TCH uses the industry standard of 3rd available appointment as a measure of access to care - ideal access would be less than 14 days. However, given the increasing demand for these specialized services for the majority of FY10 and FY11, the average 3rd Available appointment was less than 30 days. Over the last 6 months of 2012, at our Texas Medical Center site and other community locations (except our West Campus clinic), exceeds 30 days.
Goals and Relationship to Regional Goals:

Project Goals: To meet the growing demand for acute pediatric Otolaryngology services, TCH will:

1. Focus on provider productivity to optimize clinical time for all providers and enhance training of subspecialists and fellows,
2. Establish an initiative to review scheduling processes to increase the appointment availability of these targeted providers that aligns with new clinic capacity,
3. Expand provider capacity by hiring additional clinicians and support staff,
4. Enhance service availability by targeting new providers to not only work in the Texas Medical Center but also serve 1-3 additional community locations for specialty care.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients’ needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Challenges:

In Texas, limited Medicaid reimbursement is an ongoing challenge for children’s hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children’s health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded.

Five year expected outcome for provider and patients:

Texas Children’s Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:

The baseline for patient volumes in FY 12 is 12,150 18,252 across all locations of care. Our fiscal year runs from October 1st to September 30th. The average 3rd Next Available appointment across all locations of care for a New Patient Visit for FY12 was 13 days. The baseline patient cycle time for FY12 in minutes: CCC – 85; Clear Lake Health Center – 90; CyFair Health Center 124 Sugarland Health Center – 65; West Campus – 85 minutes; The Woodlands Health Center – 69. The average across all locations of care 84 (note this is not a weighted average and includes time that the patient spends alone this is not average of minutes spent with provider).
Rationale:
This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH’s existing pediatric otolaryngology services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. In order to increase access Otolaryngology is working to expand its services with a Voice & Swallowing clinic and multi-disciplinary Aerodigestive clinic. The expansion of this service is necessary as many of our patients have medically complex conditions involving the airway, pulmonary function, upper digestive tract, as well as feeding disorders resulting from prematurity, congenital anomalies, trauma, etc. To improve patient outcomes and overall health status of these patients, access must be enhanced so that conditions can be treated timely and effectively.

Project Components:
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.
   a. Conduct specialty care gap assessment based on community need for subspecialty.
   b. Implement transparent standardized referrals across the system
   c. Increase specialty care volume of visits and evidence of improved access for patients seeking services
   d. Increase service availability hours and increase number of specialty clinic locations.
   e. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges. It is our goal to reach the industry standard of less than 14 days for the 3rd available appointment.
Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.1

Milestones and Metrics
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.
   • Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
   • Improvement milestones and metrics: I-23 (I-23.1)

Unique community need identification number the project addresses:
   • CN.2: Inadequate access to specialty care.
   • CN.6: Inadequate access to treatment and services designed for children.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
The resources provided by this project will allow us to significantly expand our current program. Increased collaboration and the ability to grow programs are currently things we focusing on. To provide comprehensive multidisciplinary care for our patients the Otolaryngology Division has

partnerships with other departments within the hospital including Audiology, Speech Language and Learning, Pediatric General Surgery, Texas Children’s Cancer Center, Neurology, Pediatric Radiology, GI, Pulmonary, and Plastic Surgery.

**Related Category 3 Outcome Measure(s):**
OD-5 Cost of Care  
IT-5.1: Improved cost savings  
IT-5.2: Per episode of care cost  
IT-5.3: Length of stay

OD -1 Primary Care and Chronic Disease Management  
IT-1.1: Third Next Available Appointment

**Reasons/rationale for selecting the outcome measures:**
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs. Due to continued growth in demand for patient care services, the outcome measure of 3rd next available appointment must be considered in addition to the metric of patient visit volume growth, compared to the baseline to be able to truly measure patient access. While at the same time we are striving to increase patient access we will need to continue to focus on delivering quality, efficient, cost effective care.

**Relationship to other Projects:** All of Texas Children’s projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

**Relationship to Other Performing Providers’ Projects:** This project will compliment other projects designed to improve appropriate access to specialty care, improve chronic care management, and those designed to improve the patient experience.

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

**Project Valuation:** This project’s value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation also includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric

---

The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---

<table>
<thead>
<tr>
<th>Related Category 3: Outcome Measure(s):</th>
<th>1.9.2</th>
<th>A-D</th>
<th>EXPAND ACCESS TO SPECIALTY CARE: OTOLARYNGOLOGY PEDIATRIC CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>139135109.1.12</td>
<td></td>
<td></td>
<td>Texas Children’s Hospital</td>
</tr>
<tr>
<td>139135109.3.30</td>
<td>IT-5.1</td>
<td></td>
<td>Improved cost savings</td>
</tr>
<tr>
<td>139135109.3.31</td>
<td>IT-5.2</td>
<td></td>
<td>Per episode of care cost</td>
</tr>
<tr>
<td>139135109.3.32</td>
<td>IT-5.3</td>
<td></td>
<td>Length of stay</td>
</tr>
<tr>
<td>139135109.3.53</td>
<td>IT-1.1</td>
<td></td>
<td>Third Next Available Appointment</td>
</tr>
</tbody>
</table>

### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1 (P-1):** Conduct specialty care gap assessment to determine barriers to accessing subspecialty care

**Metric 1 P-1.1:** Documentation of gap assessment

- Data Source: Gap Assessment
- Milestone 1 Estimated Incentive Payment: $479,375

**Milestone 2 (P-21):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

**Metric 1 [P-8.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

- Goal: Participate in all semi-annual face-to-face meetings or seminars organized by the RHP.

### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 3 (P-17):** Implement the redesign of Texas Children’s Otolaryngology Clinic to increase operational efficiency, shorten patient cycle time and increase provider productivity. Increase clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 (P-17.1):** Number of specialty clinics that have completed clinic redesign. Demonstrate improvement over prior reporting period (baseline established in FY12).

- Numerator: Average cycle time of appointments in Orthopedic Surgery clinic that has performed process improvements with patient flow and clinic workflow Documentation of increased number of visits.
- Denominator: Overall average cycle time of appointments in the Orthopedics Clinic Total number of visits for reporting period

- Data Source: Epic/EDW

**Goal:** Increase clinic volume 3% across all locations of care which is 548 additional visits across all

### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 5 (I-23):** Increase clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 (I-23.1):** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12).

- a. Total number of visits for reporting period
- b. Data Source: EPIC/EDW

**Goal:** Increase clinic volume 3% across all locations of care which is 1,112 additional visits compared to baseline

**Milestone 5 Estimated Incentive Payment:** $524,492.50

### Year 5 (10/1/2015 – 9/30/2016)

**Milestone 6 (P-21):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do)

**Metric 1 (I-23.1):** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12).

- a. Total number of visits for reporting period
- b. Data Source: EPIC/EDW

**Goal:** Increase clinic volume 6% across all locations of care which is 1,692 additional visits compared to baseline

**Milestone 7 Estimated Incentive Payment:** $433,276.50

### Related Outcome Measures:

- **Per episode of care cost**
- **Length of stay**

**Further Information:**

- **Third Next Available Appointment**
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>139135109.1.12</th>
<th>1.9.2</th>
<th>A-D</th>
<th>EXPAND ACCESS TO SPECIALTY CARE: OTOLARYNGOLOGY PEDIATRIC CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Children’s Hospital</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Improved cost savings</td>
<td>139135109.3.30</td>
<td>IT- 5.1</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Per episode of care cost</td>
<td>139135109.3.31</td>
<td>IT-5.2</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Length of stay</td>
<td>139135109.3.32</td>
<td>IT-5.3</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Third Next Available Appointment</td>
<td>139135109.3.53</td>
<td>IT 1.1</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>locations of care compared to baseline Data Source: EPIC/ EDW</td>
<td>to “raise the floor” for performance. Each participating provider should publicly commit to implementing these improvements.</td>
<td>“raise the floor” for performance. Each participating provider should publicly commit to implementing these improvements.</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $479,375</td>
<td>Milestone 3 Estimated Incentive Payment: $522,972.50</td>
<td>Metric 1 [P-21.1]: Participate in semiannual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semiannual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>Metric 1 [P-21.1]: Participate in semiannual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semiannual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment: $522,972.50</td>
<td>Goal: Participate in all semiannual face-to-face meetings or seminars.</td>
<td>Milestone 6 Estimated Incentive Payment: $524,492.50</td>
<td>Milestone 8 Estimated Incentive Payment: $433,276.50</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>139135109.3.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>139135109.3.31</td>
<td>IT-5.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>139135109.3.32</td>
<td>IT-5.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>139135109.3.53</td>
<td>IT-5.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>139135109.3.53</td>
<td>IT 1.1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2** (10/1/2012 – 9/30/2013)

- **Improved cost savings**
- **Per episode of care cost**
- **Length of stay**
- **Third Next Available Appointment**

- **Year 2 Estimated Milestone Bundle Amount:** $958,750

**Year 3** (10/1/2013 – 9/30/2014)

- **Year 3 Estimated Milestone Bundle Amount:** $1,045,945

**Year 4** (10/1/2014 – 9/30/2015)

- **Year 4 Estimated Milestone Bundle Amount:** $1,048,985

**Year 5** (10/1/2015 – 9/30/2016)

- **Year 5 Estimated Milestone Bundle Amount:** $866,553

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**

- **(add milestone bundle amounts over Years 2-5):** $3,920,233
Project Option 1.9.2- Expand Access to Specialty Care

**Unique RHP Project ID:** 139135109.1.13  
**Performing Provider Name/TPI:** Texas Children’s Hospital/ 139135109

**Project Summary:** Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients needing treatment and surgical correction of cleft lip and palate anomalies amongst other diagnosis.

**Provider:**  
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765</td>
<td>Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%</td>
<td>Hispanic- African American- Caucasian- Asian- Other- American Indian-</td>
</tr>
</tbody>
</table>

**Intervention(s):** The Plastic Surgery division has and will continue to add clinic coverage at Texas Children’s West Campus and expand its clinical locations. Other programs the division is working to establish are hand and microvascular surgery, Craniosynostosis, Peripheral Nerve, Oral Surgery, and Orthognathic Surgery.

**Need for the project:** There is no ACGME Pediatric Plastics program, so many of the providers dip into the adult practice as well as pediatric. Plastic Surgery can be invaluable to help children’s psychological needs that are associated with deformities. Given the high demand and provider shortage currently the average 3rd Available for a patient with a cleft lip and palate diagnosis is greater than 30 days.

**Target Population:** Our target population is pediatric patients needing treatment and surgical correction of cleft lip and palate anomalies amongst other diagnosis.

**Category 1 or 2 expected patient benefits:**
I-23.1: Our goal is to increase the number of visits by 3% in DY3 which is an additional 123 visits compared to the baseline, by 3% in DY4 which is an additional 250 patient visits compared to baseline, and by 6% in DY5 which is an additional 380 patient visits compared to baseline established in DY2.

**Category 3 outcomes:**
OD 5 – Cost of Care
IT-5 Improving Cost of Care
IT 5.2: Per Episode Cost of Care
IT 5.3: Other Outcome Improvement Target: Reduced Length of Stay

OD 1 – Primary care and Chronic Disease Management
IT-1.1: Third Next Available Appointment
Project Option: 1.9.2 Expand Access to Specialty Care: Pediatric Plastic Surgery

Unique Project ID: 139135109.1.13

Performing Provider Name/TPI: Texas Children’s Hospital/139135109

Project Description:

*Texas Children’s Hospital proposes to expand capacity for Pediatric Plastic Surgery.*

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrics group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Specifically, this project will increase capacity within Pediatric Plastic Surgery. Funding for this project will allow Texas Children’s to fulfill our tri-part mission of providing quality pediatric care, training the next generation of pediatric providers and investigating ways to improve care through innovative therapies. The Texas Children's ("TCH") Plastic Surgery Division provides treatment and surgical correction of cleft lip and palate anomalies amongst other diagnosis. The Plastic Surgery Division recently began performing Orthognathic Surgery, a specialized procedure to help correct the misalignment of the upper and lower jaws in certain types of cleft palate disorders. Plastic Surgery has and will continue to add clinic coverage at Texas Children’s West Campus, and expand its clinical locations. Other programs the Plastic Surgery Division is working to establish are hand and microvascular surgery, Craniosynostosis, Peripheral Nerve, and Oral Surgery. TCH uses the industry standard of 3rd available appointment as a measure of access to care - ideal access would be less than 14 days. However, given the high demand and provider shortage, currently the average 3rd Available for a patient with a cleft lip and palate diagnosis is greater than 30 days.

Goals and Relationship to Regional Goals:

Project Goals: To meet the growing demand for high impact pediatric plastic surgery services, TCH will:

1) Focus on provider productivity to optimize clinical time for all providers,
2) Establish an initiative to review scheduling processes to increase the availability of these targeted providers,
3) Expand internal capacity by hiring additional clinical providers and
4) Enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve 1-3 additional community locations for specialty care,
This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients’ needs throughout the entire region, and improves health care outcomes and patient satisfaction

**Challenges:** There is no ACGME Pediatric Plastics program, so many of the providers dabble in adult practice as well as pediatric. Plastic Surgery can be invaluable to help children’s psychological needs that are associated with deformities. Unfortunately, due to monetary constraints in health care budgets, corrective surgeries are often viewed as ‘elective or cosmetic’ and not reimbursable or lowly reimbursed. In Texas, limited Medicaid reimbursement is an ongoing challenge for children’s hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children’s health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded. While we continue to increase our overall outpatient volumes at all of our locations by 5.7% year over year in our pediatric physician practices, we still have not been able to significantly decrease the patient available appointment wait time. By reconfiguring clinic processes, scheduling and the addition of more providers, we will try to improve this measure.

**Five year expected outcome for provider and patients:**
Texas Children’s Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

**Starting Point/Baseline:**
The baseline of patient volume in FY 2012 is 4,099 across all locations of care. Our fiscal year runs from October 1st to September 30th.

---


**Rationale:**
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH’s existing pediatric plastic surgery services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time.

Cleft lip and palate are among the most common genetic defects in the United States. Cleft patients have complex needs that require lifelong care, treatment, and monitoring by an interdisciplinary team. The Texas Children's ("TCH") Plastic Surgery Division provides treatment and surgical correction of cleft lip and palate anomalies amongst other diagnosis. A new service TCH is looking to expand into is Orthognathic surgery which is typically done on patients to correct conditions of the jaw and face or who have bilateral cleft lip and palate. Orthognathic surgery is performed by an oral and maxillofacial surgeon, plastic surgeon or ENT in collaboration with an orthodontist.

**Project Components:** Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

- a. Conduct specialty care gap assessment based on community need for subspecialty.
- b. Implement transparent standardized referrals across the system
- c. Increase specialty care volume of visits and evidence of improved access for patients seeking services
- d. Increase service availability hours and increase number of specialty clinic locations.
- e. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges. It is our goal to reach the industry standard of less than 14 days for the 3rd available appointment.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.3

**Milestones and Metrics**
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-21 (P-21.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

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

- CN.2: Inadequate access to specialty care,
- CN.6: Inadequate access to treatment and services designed for children.

---

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

With the new offerings and increase in collaborations there will be less untreated care and less out of state travel for care for our patients and families.

**Related Category 3 Outcome Measure(s):**
OD-5 Cost of Care
IT-5.1: Improved Cost Savings
IT-5.2: Per Episode Cost of Care
IT-5.3: Length of Stay

OD-1 Primary Care and Chronic Disease Management
IT-1.1: Third Next Available Appointment

**Reasons/rationale for selecting the outcome measures:**
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs. Due to continued growth in demand for patient care services, the outcome measure of 3rd next available appointment must be considered in addition to the metric of patient visit volume growth, compared to the baseline to be able to truly measure patient access. While at the same time we are striving to increase patient access we will need to continue to focus on delivering quality, efficient, cost effective care.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

**Relationship to Other Performing Providers’ Projects:** This project will compliment other projects designed to improve appropriate access to specialty care, improve chronic care management, and those designed to improve the patient experience.

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

---

**Project Valuation:** This project’s value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation also includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---


<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Texas Children’s Hospital</th>
<th>139135109</th>
</tr>
</thead>
<tbody>
<tr>
<td>139135109.1.13</td>
<td>1.9.2 A-D EXPAND ACCESS TO SPECIALTY CARE/PEDIATRIC PLASTIC SURGERY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Related Category 3**

**Outcome Measure(s):**

- IT-5.1
- IT-5.2
- IT-5.3
- IT-1.1

**Texas Children’s Hospital**

**139135109**

### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1 (P-1):** Conduct specialty care gap assessment to determine barriers to accessing subspecialty care.

**Metric 1 [P-1.1] Documentation of gap assessment**

Data Source: Gap Assessment

Milestone 1 Estimated Incentive Payment: $688,135.50

**Milestone 2 (P-21):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

Milestone 3 Estimated Incentive Payment: $750,719

### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 3 (P-17):** Increase clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 (P-17.1):** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12).

- Total number of visits for reporting period
- Data Source: Epic/EDW

Goal: Increase clinic volume 3% across all locations of care which is an additional 123 visits compared to the baseline

Milestone 3 Estimated Incentive Payment: $750,719

### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 5 (I-23):** Increase clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 (I-23.1):** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12).

- Total number of visits for reporting period
- Data Source: Epic/EDW

Goal: Increase clinic volume 3% across all locations of care which is an additional 250 patient visits compared to baseline

Milestone 5 Estimated Incentive Payment: $752,901.50

### Year 5 (10/1/2015 – 9/30/2016)

**Milestone 7 (I-23):** Increase clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 (I-23.1):** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12).

- Total number of visits for reporting period
- Data Source: Epic/EDW

Goal: Increase clinic volume 6% across all locations of care which is an additional 380 patient visits compared to baseline

Milestone 7 Estimated Incentive Payment: $621,962

**Milestone 8 (P-21):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each
<table>
<thead>
<tr>
<th>139135109.1.13</th>
<th>1.9.2</th>
<th>A-D</th>
<th>EXPAND ACCESS TO SPECIALTY CARE/ PEDIATRIC PLASTIC SURGERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Children’s Hospital</td>
<td></td>
<td></td>
<td>139135109</td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s):</strong></td>
<td><strong>Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</strong></td>
<td><strong>Milestone 2 Estimated Incentive Payment:</strong> $688,135.50</td>
</tr>
<tr>
<td></td>
<td>139135109.3.33</td>
<td>IT-5.1</td>
<td>Improved Cost Savings</td>
</tr>
<tr>
<td></td>
<td>139135109.3.34</td>
<td>IT-5.2</td>
<td>Per Episode Cost of Care</td>
</tr>
<tr>
<td></td>
<td>139135109.3.35</td>
<td>IT-5.3</td>
<td>Length of Stay</td>
</tr>
<tr>
<td></td>
<td>139135109.3.54</td>
<td>IT-1.1</td>
<td>Third Next Available Appointment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</th>
<th><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</th>
<th><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</th>
<th><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</strong></td>
<td>meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td>At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td>face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
</tr>
<tr>
<td><strong>Goal:</strong> Participate in all semi-annual face-to-face meetings or seminars. <strong>Data Source:</strong> Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td></td>
<td></td>
<td><strong>Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</strong></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Milestone Bundle Amount:</strong> (add incentive payments amounts from each milestone): $1,376,271</td>
<td><strong>Year 3 Estimated Milestone Bundle Amount:</strong> $1,501,438</td>
<td><strong>Year 4 Estimated Milestone Bundle Amount:</strong> $1,505,803</td>
<td><strong>Year 5 Estimated Milestone Bundle Amount:</strong> $1,243,924</td>
</tr>
<tr>
<td><strong>Milestone 4 Estimated Incentive Payment:</strong> $750,719</td>
<td><strong>Milestone 6 Estimated Incentive Payment:</strong> $752,901.50</td>
<td><strong>Milestone 8 Estimated Incentive Payment:</strong> $621,962</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $5,627,436
Project Option 1.9.2- Expand Access to Specialty Care

Unique RHP Project ID: 139135109.1.14
Performing Provider Name/TPI: Texas Children’s Hospital/ 139135109

Project Summary: Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with conditions affecting the brain and neurological system

Provider:
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765</td>
<td>Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%</td>
<td>Hispanic- African American- Caucasian- Asian- Other- American Indian-</td>
</tr>
</tbody>
</table>

Intervention(s): This project will create increased capacity through more efficient operations and new provider recruitment. In order to maintain prompt access to our Neurosurgeons the division is working to expand its services by utilizing Advanced Practice Providers who can see lower acuity patients thereby freeing up our Neurosurgeons to see more complex spine and epilepsy patients, as well as be able to expand services to fetal, craniofacial and trauma cases.

Need for the project: The purpose of this project is to meet the growing demand for high impact pediatric Neurosurgery services. There are few “skilled” surgeons that focus upon Pediatric Neurosurgery. Texas Children’s Hospital became the first hospital in the world to use real-time MRI guided thermal imaging and laser technology to destroy lesions in the brain that cause Epilepsy. Currently, 100% of these post operative patients are seizure free.

Target Population:
The target population of patients being served are those patients that are comprehensive and require lifelong care.

Category 1 or 2 expected patient benefits:
I-23.1: Our goal is to increase the number of visits by 3% in DY3 which is 163 patient visits compared to baseline, by 3% in DY4 which is 332 patient visits compared to baseline, and by 6% in DY5 which is 505 patient visits compared to baseline.
Category 3 outcomes:
IT-5 Improving Cost of Care
IT 5.2: Per Episode Cost of Care
IT 5.3: Other Outcome Improvement Target: Reduced Length of Stay
IT-1.1: Third Next Available Appointment
Project Option: 1.9.2 Expand Pediatric Neurosurgery Care,

Unique Project ID/TPI: 139135109.1.14

Performing Provider Name/TPI: Texas Children’s Hospital/ 139135109

Project Description:

*Texas Children’s Hospital proposes to expand access to pediatric Neurosurgery care, enabling patients to receive care in a more timely manner and reduce wait times for appointments.*

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation’s largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Our project proposal will significantly improve access to pediatric subspecialty care. Specifically, the expansion of capacity funded by this project will allow us to increase appointment capacity in our Neurosurgery Clinic thereby improving patient access to care. While this improved access will benefit all families we expect at least half of the increased access will serve the Medicaid population. Funding for this project will allow Texas Children’s to fulfill our tri-part mission of providing quality pediatric care, training the next generation of pediatric providers and investigating ways to improve care through innovative therapies.

Funding for this project will allow Texas Children’s to fulfill our tri-part mission of providing quality pediatric care, training the next generation of pediatric providers and investigating ways to improve care through innovative therapies. The Texas Children's ("TCH") Neurosurgery Division is ranked # 5 in the 2012 U.S. News and World Report Best Children's Hospitals. We are one of the largest pediatric neurosurgery units in the United States. We take a collaborative approach to care; working closely with Texas Children’s Cancer Center, Texas Children’s Fetal Center, the comprehensive Epilepsy Program, neurology, adolescent medicine, developmental pediatrics, interventional neuroradiology, and trauma. In 2011, Texas Children’s Hospital became the first hospital in the world to use real-time MRI guided thermal imaging and laser technology to destroy lesions in the brain that cause Epilepsy. Currently, 100% of these post operative patients are seizure free.

**Project Goals:** To meet the growing demand for high impact pediatric Neurosurgery services, TCH will:

1. Focus on provider productivity to optimize clinical time for all providers,
2. Establish an initiative to review scheduling processes to increase the availability of these targeted providers,
3. Expand internal capacity by hiring additional clinical providers, and
4. Enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve 1-3 additional community locations.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients’ needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Challenges: The challenges we are faced with are that these patients are comprehensive and require lifelong care. There are few “skilled” surgeons that focus upon Pedi Neurosurgery. There is the possibility of taking the Neurosurgery program out to West Campus but that would depend of Neurology focus and the expansion of the epilepsy and Vagas nerve stimulator – which require significant financial and intellectual investment. In Texas, limited Medicaid reimbursement is an ongoing challenge for children’s hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children’s health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded. While we continue to increase our overall outpatient volumes at all of our locations by 5.7% year over year in our pediatric physician practices, we still have not been able to significantly decrease the patient available appointment wait time. By reconfiguring clinic processes, scheduling and the addition of more providers, we will try to improve this measure.

Five year expected outcome for provider and patients:
Texas Children’s Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline: Our fiscal year runs from October 1st to September 30th. The average 3rd available appointment at the TCH Neurosurgery Division is less than 14 days. The baseline for patient volumes in FY 12 is 5,449

Rationale:
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. In order to maintain prompt access to our Neurosurgeons the division is working to expand its services by utilizing the use of Advance Care Providers. These providers are able see the division’s lower acuity patients thereby freeing up our neurosurgeons to see more complex spine and epilepsy patients, as well as be able to expand services to fetal, craniofacial and trauma cases. The NPPs are also able to see more patients in the Neonatal and Pediatric Intensive Care Units and provide...
the continuum of care from the inpatient stay through the necessary follow up in the outpatient clinic setting.

**Project Components:** Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

a. Conduct specialty care gap assessment based on community need for subspecialty.
b. Implement transparent standardized referrals across the system
c. Increase specialty care volume of visits and evidence of improved access for patients seeking services
d. Increase service availability hours and increase number of specialty clinic locations.
e. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges. It is our goal to reach the industry standard of less than 14 days for the 3rd available appointment.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.\(^1\)

**Milestones and Metrics**
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1);

Customizable Improvement Milestone and Metric was chosen in order to specifically tailor the intent of project to the targeted pediatric population.

**Unique community need identification number the project addresses:** CN.2: Inadequate access to specialty care., CN.6: Inadequate access to treatment and services designed for children.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** This project will allow Texas Children’s to significantly enhance our existing Neurosurgery appointment availability. With the shortage of specialists in this area, TCH has had to work within the resources available nationwide to build a program that provides superior care for children with these conditions. This expansion project, through its focus on national recruitment as well as the use of mid-level providers for care, aims to improve access to these services for children in the state of Texas.

**Related Category 3 Outcome Measure(s):**
**OD-5 Cost of Care**
IT 5.1: Improved Cost Savings
IT 5.2: Per Episode Cost of Care

---

IT 5.3: Other Outcome Improvement Target: Reduced Length of Stay

OD-1 Primary Care and Chronic Disease Management
IT-1.1: Third Next Available Appointment

**Reasons/rationale for selecting the outcome measures:**
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.\(^2\) Due to continued growth in demand for patient care services, the outcome measure of 3\(^{rd}\) next available appointment must be considered in addition to the metric of patient visit volume growth, compared to the baseline to be able to truly measure patient access. While at the same time we are striving to increase patient access we will need to continue to focus on delivering quality, efficient, cost effective care.

**Relationship to other Projects:** All of Texas Children’s projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

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

**Project Valuation:** This project’s value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^3\) Our valuation also includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric

---


The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---

Goal: Participate in all semi-annual seminars organized by the RHP.

Metric 1 [P-21.1]: Number of face-to-face meetings or seminars. Each participating provider should publicly commit to implementing these improvements. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care

**Metric P-1.1** Documentation of gap assessment

Data Source: Gap Assessment

Milestone 1 Estimated Incentive Payment: $327,962

Milestone 2 (P-21)

Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

**Metric 1 [P-21.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of...
<table>
<thead>
<tr>
<th>139135109.1.14</th>
<th>1.9.2</th>
<th>1.9.2 A-D</th>
<th>EXPAND SPECIALTY ACCESS TO NEUROSURGERY CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Texas Children’s Hospital</td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s):</strong></td>
<td>IT-5.1</td>
<td>Cost of Care</td>
</tr>
<tr>
<td><strong>Outcome Measure(s):</strong></td>
<td>139135109.3.36</td>
<td>IT-5.2</td>
<td>Per Episode of care cost</td>
</tr>
<tr>
<td></td>
<td>139135109.3.37</td>
<td>IT-5.3</td>
<td>Length of Stay</td>
</tr>
<tr>
<td></td>
<td>139135109.3.38</td>
<td>IT- 1.1</td>
<td>Third Next Available Appointment</td>
</tr>
<tr>
<td></td>
<td>139135109.3.55</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. <strong>Metric 1 [P-21.1]:</strong> Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $357,789</td>
<td>initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. <strong>Metric 6 [P-21.1]:</strong> Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $358,829</td>
<td>“raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. <strong>Metric 8 [P-21.1]:</strong> Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $296,424</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $655,924  
**Year 3 Estimated Milestone Bundle Amount:** $715,578  
**Year 4 Estimated Milestone Bundle Amount:** $717,658  
**Year 5 Estimated Milestone Bundle Amount:** $592,848

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $2,682,008
Project Option 1.9.2- Expand Access to Specialty Care

Unique RHP Project ID: 139135109.1.15
Performing Provider Name/TPI: Texas Children’s Hospital/ 139135109

Project Summary: Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with simple to high complex acute or chronic orthopedic problems.

Provider:
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation’s largest general pediatrician group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765</td>
<td>Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%</td>
<td>Hispanic- African American- Caucasian- Asian- Other- American Indian-</td>
</tr>
</tbody>
</table>

Intervention(s): The division is working to enhance its sub-specialization in the following areas of Sports Medicine, Orthopedic Oncology, Leg and Limb Deformity, and Hand/Upper Extremity. TCH West Campus will expand services to include a new sports medicine program.

Need for the project: The division of Orthopedics provides 24/7 emergency coverage at TCH Medical Center Campus, Outpatient, Operating Room, and emergency services at TCH West Campus. The number of children referred into the TCH Orthopedics clinic averages 230 referrals per month. In FY10 and FY11 the average 3rd Available appointment at the TCH Orthopedics clinic is greater than 30 days. Due to the demand and the wait times and access into the service our patients do not get the care they need and therefore are faced living with “treatable” deformities.

Target Population: Our target population is pediatric patients with simple to high complex acute or chronic orthopedic problems. One particular area of focus will be the interdisciplinary Sports Medicine program for patients from the physically active to the pediatric or adolescent athlete.

Category 1 or 2 expected patient benefits:
I-23.1: Our goal is to increase the number of visits by 3% in DY3 which is an additional 622 visits compared to baseline, by 3% in DY4 which is an additional 1,262 patient visits compared to baseline, and by 6% in DY5 which is an additional 1,922 patient visits compared to baseline.
Category 3 outcomes:
IT-5 Improving Cost of Care
IT 5.2: Per Episode Cost of Care
IT 5.3: Other Outcome Improvement Target: Reduced Length of Stay

OD 1 – Primary Care and Chronic Disease Management
IT-1.1: Third Next Available Appointment
Project Option -1.9.2 Expand Access to Specialty Care: Orthopedic Pediatric Care

**Unique Project ID:** 139135109.1.15

**Performing Provider Name/TPI:** Texas Children’s Hospital/ 139135109

**Project Description:**
*Texas Children’s Hospital proposes to expand access to pediatric orthopedic care, enabling patients to receive care in a more timely manner and reduce wait times for appointments.*

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Our project proposal will significantly improve access to pediatric subspecialty care. The Texas Children's ("TCH") Orthopedics Division is ranked # 33 in the 2012 U.S. News and World Report Best Children's Hospitals. Orthopedics provides 24/7 emergency coverage at TCH. Outpatient, Operating Room, and emergency services are available at TCH West Campus, and clinics are held at all TCH Health Center locations. From minor fractures to complex disorders the Orthopedic Surgery division at Texas Children’s Hospital provides exemplary care for pediatric patients from newborn to skeletal maturity with simple to high complex acute or chronic orthopedic problems. In 2010, the Orthopedic Surgery division established the Adolescent and Young Adult Hip clinic, the only one of its kind in the region and focuses on diagnosis and treatment of hip conditions.

The division is currently working to continue to enhance is sub-specialization in the following areas of Sports Medicine, Orthopedic Oncology, Leg and Limb Deformity, and Hand/Upper Extremity. Texas Children’s West Campus will expand patient services to include a new Sports Medicine Program dedicated to treating children for all types of sports-related injuries and disorders. This new program will utilize an interdisciplinary approach for the diagnosis, evaluation and treatment of children and adolescents from the physically active to the pediatric or adolescent athlete. Currently referrals into the TCH pediatric Orthopedics clinic average 230 referrals per month. New programs within the Orthopedic Surgery Department include Sports Medicine, Ortho Oncology, Leg and Limb Deformities, and Hand and Upper Extremity subspecialization. TCH uses the industry standard of 3rd available appointment as a measure of access to care - ideal access would be less than 14 days. However, given the high demand and provider shortage, for the majority of FY10 and FY11, the average 3rd Available appointment at the TCH Orthopedics clinic is greater than 30 days.

**Goals and Relationship to Regional Goals:**
Project Goals: To meet the growing demand for acute pediatric orthopedic services, TCH will:

- Focus on provider productivity to optimize clinical time for all providers and enhance training of subspecialists and fellows,
- Establish an initiative to review scheduling processes to increase the appointment availability of these targeted providers that aligns with new clinic capacity,
- Expand provider capacity by hiring additional clinicians and support staff,
- Expand service availability through the provision of services with additional providers not only in the Texas Medical Center clinic site, but also in at least 1-3 community care settings.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients’ needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges:
Some of the challenges we may face while trying to improve access in the Orthopedics area is with providers who have an adult practice as well as pediatric patient panel. Due to demand and the wait times and access into the service our patients do not get the care need, and therefore are faced living with “treatable” deformities. In many cases these deformities can lead to other health issues. In Texas, limited Medicaid reimbursement is an ongoing challenge for children’s hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children’s health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded. While we continue to increase our overall outpatient clinic volumes at all of our locations by 5.7% year over year in our pediatric physician practices, we still have not been able to significantly decrease the patient available appointment wait time. By reconfiguring clinic processes, scheduling and the addition of more providers, we will try to improve this measure.

Five year expected outcome for provider and patients:
Texas Children’s Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:
The average 3rd Available appointment at the TCH Orthopedics clinic is greater than 30 days. The baseline of patient volumes in FY 12 is 20,728, 6,350. Our fiscal year runs from October 1st to September 30th. The average 3rd Next Available appointment for a New Patient Visits across all locations of care for FY12 was 13 days. The baseline average patient cycle time in FY12 in
minutes: Clinical Care Center-90 minutes; Clear Lake Health Center-87 minutes; CyFair – 96 minutes; Sugarland- 98 minutes; The Woodlands-78 minutes; West Campus – 85 minutes. (Note this is not a weighted average and includes time that the patient spends alone this is not average of minutes spent with provider)

**Rationale:**

**Reasons for selecting project option:**
Pediatric orthopedic specialists diagnose, treat, and manage children's musculoskeletal problems including Limb and spine deformities (such as club foot, scoliosis), Gait abnormalities (limping), Bone and joint infections and broken bones. Texas Children’s Hospital is a level 1 trauma center; therefore, sees an increasing number of children who may require orthopedic services. Likewise, its orthopedics division is nationally recognized for its treatment and diagnosis of rare musculoskeletal diseases/abnormalities. For many families living in the Gulf coast region of the United States, our orthopedics department is the sole point of care for their medically complex child or a child who may suffer from a rare bone/muscular abnormality or joint disorder.

**Project Components:**
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

- a. Conduct specialty care gap assessment based on community need for subspecialty.
- b. Implement transparent standardized referrals across the system
- c. Increase specialty care volume of visits and evidence of improved access for patients seeking services
- d. Increase service availability hours and increase number of specialty clinic locations.
- e. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges. It is our goal to reach the industry standard of less than 14 days for the 3rd available appointment.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.\(^1\)

The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-21 (P-21.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1); I-X (I-X.1)

Customizable Improvement Milestone and Metric was chosen in order to specifically tailor the intent of project to the targeted pediatric population.

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

• CN.2: Inadequate access to specialty care. CN.6: Inadequate access to treatment and services designed for children.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project will significantly enhance current services by providing new care to the patient population. Expanding locations provides increased access and convenience for patients and their families. Also being able to utilize a health system for best outcomes thru a multi-specialty collaboration will enhance the existing delivery system initiative.

Related Category 3 Outcome Measure(s):
OD-5 Cost of Care
IT 5.1: Improved Cost Savings
IT 5.2: Per Episode Cost of Care
IT 5.3: Other Outcome Improvement Target: Reduced Length of Stay

OD -1 Primary Care and Chronic Disease Management
IT-1.1: Third Next Available Appointment

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs. Due to continued growth in demand for patient care services, the outcome measure of 3rd next available appointment must be considered in addition to the metric of patient visit volume growth, compared to the baseline to be able to truly measure patient access. While at the same time we are striving to increase patient access we will need to continue to focus on delivering quality, efficient, cost effective care.

Relationship to other Projects: All of Texas Children’s projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will

facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region’s health care system.

**Project Valuation:** This project’s value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.³ Our valuation also includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.⁴ The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.


<table>
<thead>
<tr>
<th>139135109.1.15</th>
<th>I.9.2</th>
<th>A-D</th>
<th>EXPAND SPECIALTY ACCESS TO ORTHOPEDIC SURGERY CARE</th>
<th>139135109</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 3</td>
<td>139135109.3.39</td>
<td>IT-5.1</td>
<td>Improved Cost Savings</td>
<td>1.9.2</td>
</tr>
<tr>
<td>Outcome Measure(s):</td>
<td>139135109.3.40</td>
<td>IT-5.2</td>
<td>Per Episode Cost of Care</td>
<td>A-D</td>
</tr>
<tr>
<td></td>
<td>139135109.3.41</td>
<td>IT-5.3</td>
<td>Other Outcome Improvement Target: Reduced Length of Stay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>139135109.3.56</td>
<td>IT-1.1</td>
<td>Third Next Available Appointment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 1 (P-1):</strong> Conduct specialty care gap assessment to determine barriers to accessing subspecialty care</td>
<td><strong>Milestone 3 (P-17):</strong> Implement process improvements of Texas Children’s Orthopedic Surgery Clinic to increase operational efficiency, shorten patient cycle time and increase provider productivity. Increase clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td><strong>Milestone 5 (I-23):</strong> Increase clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td><strong>Milestone 7 (I-23):</strong> Increase clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-1.1]: Documentation of gap assessment</td>
<td>Metric 1 [P-17.1]: Number of specialty clinics that have completed clinic redesign. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Numerator: Average cycle time of appointments in Orthopedic Surgery clinic that has performed process improvements with patient flow and clinic workflow Documentation of increased number of visits. b. Denominator: Overall average cycle time of appointments in the Orthopedics Clinic Total number of visits for reporting period Data Source: Epic/Enterprise Data Warehouse, HR staffing and timesheets Goal: Increase clinic volume 3% across all locations of care which is an additional 622 patient visits compared to baseline</td>
<td>Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Epic/EDW Goal: Increase clinic volume 6% across all locations of care which is an additional 1,262 patient visits compared to baseline</td>
<td>Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Epic/EDW Goal: Increase clinic volume 6% across all locations of care which is an additional 1,922 patient visits compared to baseline.</td>
<td></td>
</tr>
<tr>
<td>Data Source: Gap Assessment</td>
<td></td>
<td></td>
<td>Milestone 7 Estimated Incentive Payment: $973,037.50</td>
<td>Milestone 7 Estimated Incentive Payment: $803,813.50</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $889,335.50</td>
<td></td>
<td></td>
<td>Milestone 5 Estimated Incentive Payment: $973,037.50</td>
<td>Milestone 7 Estimated Incentive Payment: $803,813.50</td>
</tr>
<tr>
<td><strong>Milestone 2 (P-21):</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td><strong>Milestone 4 (P-21):</strong> Reduce Length of Stay (LOS) for Orthopedic Surgery patients receiving care at Texas Children’s Hospital.</td>
<td><strong>Milestone 6 (P-21):</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</td>
<td></td>
<td></td>
<td>Milestone 8 [P-21]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td></td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan
Region 3
816
## A-D
### EXPAND SPECIALTY ACCESS TO ORTHOPEDIC SURGERY CARE

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>1-39135109.1.15</th>
<th>1.9.2</th>
<th>A-D</th>
<th>139135109.3.39</th>
<th>139135109.3.40</th>
<th>139135109.3.41</th>
<th>139135109.3.56</th>
<th>Improved Cost Savings Per Episode Cost of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome Measure(s):</strong></td>
<td>139135109.1.15</td>
<td></td>
<td></td>
<td>IT-5.1</td>
<td>IT-5.2</td>
<td>IT-5.3</td>
<td>IT-1.1</td>
<td>Other Outcome Improvement Target: Reduced Length of Stay</td>
</tr>
<tr>
<td><strong>Goal:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Third Next Available Appointment</td>
</tr>
</tbody>
</table>

### Year 2 (10/1/2012 – 9/30/2013)
- **Goal:** Participate in all semi-annual face-to-face meetings or seminars.
- **Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.
- **Milestone 2 Estimated Incentive Payment:** $889,335.50

### Year 3 (10/1/2013 – 9/30/2014)
- **Milestone 3 Estimated Incentive Payment:** $970,217

### Year 4 (10/1/2014 – 9/30/2015)
- **Milestone 4 [P-21]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.
- **Metric 1 [P-21.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.
- **Milestone 6 Estimated Incentive Payment:** $973,037.50

### Year 5 (10/1/2015 – 9/30/2016)
- **Milestone 8 Estimated Incentive Payment:** $803,813.50

- **Milestone 4 [P-21]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.
- **Metric 1 [P-21.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Improved Cost Savings Per Episode Cost of Care</th>
<th>Other Outcome Improvement Target: Reduced Length of Stay Third Next Available Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Children’s Hospital</td>
<td>139135109.3.39</td>
<td>IT-5.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>139135109.3.40</td>
<td>IT-5.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>139135109.3.41</td>
<td>IT-5.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>139135109.3.56</td>
<td>IT-1.1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone):</td>
<td>$1,778,671</td>
<td>Year 3 Estimated Milestone Bundle Amount:</td>
<td>$1,940,434</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Year 4 Estimated Milestone Bundle Amount:</td>
<td>$1,946,075</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Year 5 Estimated Milestone Bundle Amount:</td>
<td>$1,607,627</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $7,272,807
Project Option 1.9.2- Expand Access to Specialty Care

Unique RHP Project ID: 139135109.1.16
Performing Provider Name/TPI: Texas Children’s Hospital/ 139135109

Project Summary:
To increase access in providing women’s reproductive mental health services to the meet the needs of this population.

Provider:
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric and women’s patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765</td>
<td>Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%</td>
<td>Hispanic- African American- Caucasian- Asian- Other- American Indian-</td>
</tr>
</tbody>
</table>

Intervention(s):
This project will allow us to create access resources which will allow us to diagnosis women quicker and enhance their quality of life. Educating and training obstetricians and pediatricians to improve screening in post-partum depression, to understand the challenges of psychiatric medications during pregnancy and breastfeeding, and to understand the mental health needs of menopausal women.

Need for the project:
This project will increase access for women with reproductive mental health issues. American women are two times more likely to experience depression than men and depression is considered to be the leading cause of disease-related disability among women today. Approximately 13-15% of new mothers are diagnosed with Postpartum Depression (PPD).

Target Population:
All women within the Houston community who can benefit from this project, specifically with reproductive mental health issues.

Category 1 or 2 expected patient benefits:
Our DY 4 goal is to increase patient visits by 10% from the baseline in fiscal year 2012 of 700 patients or 70 additional patients in DY 4. DY5 goal is to increase patient visits by 20% from the baseline in fiscal year 2012 or 140 additional patients in DY 5.

Category 3 outcomes:
OD-1 Primary Care and Chronic Disease Management
IT-1.1 Third next available appointment
OD-10 Quality of Life/Functional Status
IT-10.1 Quality of Life
Project Option: 1.9.2 Improve access to specialty care: Expand Women’s Mental Health Care

Unique Project ID: 139135109.1.16

Performing Provider Name/TPI: Texas Children’s Hospital/ 139135109

Project Description: Texas Children’s Hospital will expand provider capacity, improve processes and increase availability of mental health services for women

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country. Our mission is to provide the finest possible pediatric and women’s patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of women and children locally, nationally and internationally.

In November 2011, Texas Children’s Hospital embarked on a unique opportunity and built a state of the art Pavilion for Women to provide comprehensive inpatient and outpatient services in Obstetrical and Gynecological care. In addition, the Pavilion for Women has recently opened The Women’s Place - Center for Reproductive Psychiatry. It is one of only a handful of programs in the United States dedicated to the care and treatment of women’s reproductive mental health issues. The services offered will range from premenstrual dysphoric disorder, prenatal evaluation and treatment, care, postpartum mental health care, perimenopausal and menopausal mental health conditions. Our philosophy is to focus on the health of women because it leads to healthy families.

Approximately 13-15% of new mothers are diagnosed with Postpartum Depression (PPD). The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) defines PPD as a nonpsychotic, major depressive disorder with a specifier of postpartum onset within 4 weeks after childbirth. Among younger and socioeconomically disadvantaged mothers, the prevalence is even higher: about 1 in 4 women. Other risk factors for developing PPD include a history of depression, experience of depression or anxiety during the pregnancy, or a family history of psychiatric illness. Also, a woman’s relationship with her partner can be a predictive variable for PPD; women that are less satisfied, have higher levels of conflict, and receive less support from their partners are potentially at greater risk for PPD. Evidence suggests that some mental illnesses are more prevalent in women; that women use mental health services more frequently than men do and that women want a different range of treatment and support options than is currently available. Additionally, women’s mental health


needs change across their lifespan. Specifically during the postpartum period, about 85% of women experience some type of mood disturbance. (Massachusetts General Center for Woman’s Mental Health, http://www.womensmentalhealth.org/specialty-clinics/postpartum-psychiatric-disorders/) For most the symptoms are mild and short-lived; however, 10% to 15% of women develop more significant symptoms of depression or anxiety. Postpartum psychiatric illness is typically divided into three categories: (1) postpartum blues (2) postpartum depression and (3) postpartum psychosis. Mental illness can also occur during pregnancy and women require expert help in determining which treatments, including medication are safe during pregnancy.

Without expert care women are more likely to not receive treatment or to abruptly discontinue psychiatric medication which can have serious negative consequences for both mother and child. Evidence supports that untreated maternal depression can have negative consequences for her child, including increased risk of school problems, psychiatric illness, and even physical illness such as reactive airway disease. http://www-ncbi-nlm-nihgov.ezproxyhost.library.tmc.edu/pubmed/19850709.

Additionally, studies have shown that PPD can be accompanied by altered emotional attachment and interference in mother-infant bonding which in turn leads to poorer cognitive outcomes and physiologic changes for the child.\(^6\)\(^,\)\(^7\)\(^,\)\(^8\)\(^,\)\(^9\)\) Given the importance of a mother’s mental health on her baby’s well-being, the American Academy of Pediatrics (AAP) released a recent report which recommends that pediatricians screen mothers for postpartum depression at baby’s one-, two-, and four-month visits.\(^10\) To screen for depression, the AAP recommends using either the Edinburgh Postnatal Depression Scale (EPDS) or a two-question screen. The EPDS is a 10-question screen, completed by the mother, which has been extensively validated by several studies.\(^11\)\(^,\)\(^12\)\(^,\)\(^13\)\(^,\)\(^14\) Additionally, children of these depressed mothers tend use more healthcare resources. Specifically, the children of mothers who are depressed are taken to their pediatrician more often.

more often, more frequently admitted to the hospital and more often prescribed medication for minor childhood illnesses than those of non-depressed mothers.\(^\text{15}\)

**Goals and Relationship to Regional Goals:**

**Project Goals:**

To meet the growing demand for high impact reproductive psychiatry services, TCH will:

1. Focus on provider productivity to optimize clinical time for all providers and enhance training of subspecialists and trainees.
2. Establish an initiative to review scheduling processes to increase the appointment availability of these targeted providers that aligns with new clinic capacity.
3. Expand provider capacity by hiring additional clinicians and support staff, in order to offer non-medical treatments to pregnant and breastfeeding mothers with depression.
4. Enhance service availability by targeting new providers to not only work in the Texas Medical Center but also serve additional 1-2 community locations.
5. Engage pediatricians in screening mothers for postpartum depression and providing effective systems for referral and treatment.

This project meets the following Region 3 Goals:

- (CN.2, CN.15) Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients’ needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- (CN.18) Address the insufficient access to integrated care programs for behavioral health and physical health conditions as a need in our community.

**Challenges:** One of the greatest challenges in mental health is the stigma surrounding the disease. Women who are suffering from psychiatric illness during pregnancy and the postpartum period are especially afraid to seek treatment. And if women reach out for help access to mental health services is a challenge. Finding a provider who understands the unique features of women’s care during the reproductive years is particularly challenging. There are very few comprehensive women’s mental health programs across the country and we will be one of them. The Pavilion for Women is particularly unique because our women’s mental health program is embedded in the hospital where women come to seek care. Access to care is easier and more accepted than going to another facility; there is less stigma to seeking help. Across the nation, there is limited reimbursement for mental health services with private and public payors. In many instances psychiatrists have chosen a fee for service practice that is prohibitively expensive for most women. Finding a provider who is knowledgeable about the unique needs of women during the reproductive is particularly difficult. Finding expert, reimbursed care is challenging can sometimes be impossible in most communities. Because of the lack of mental health providers to treat this population many women fall through the cracks. Although it is estimated

that 10 to 15% of women will suffer from postpartum depression, most hospitals and physicians do not offer screening. If there is no mental health care available then identifying illness creates a problem with limited solutions. Although screening for postpartum depression has been advocated to be the standard of care, many health care facilities and physicians are reluctant to do so due to lack of appropriate referrals. Women are sent home with new babies and either don’t receive care or receive inadequate care. Untreated depression has increased morbidity and mortality for both mother and child.

**Five year expected outcome for provider and patients:**
Texas Children’s Hospital expects to see improvements in access to subspecialty care for our obstetric and gynecologic patients; this in turn will improve patient satisfaction and patient health due to the delivery of the right care at the right place at the right time.

**Starting Point/Baseline:**
The baseline of patient volume in FY 12 is 700. Our fiscal year runs from October 1st to September 30th.

**Rationale:**
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized women’s mental health providers. This project will create increased capacity through more efficient operations and new licensed provider recruitment. Specifically in our region there are only 3.5 providers who specialize in woman’s reproductive mental health, three of those providers provide fee for service care only. Until recently patients who for financial reasons must use insurance have been unable to access appropriate specialized care for serious mental illness during the reproductive years. Region 3 identified (CN.18). Texas Children’s Hospital is working to develop The Women’s Place - Center for Reproductive Psychiatry at Texas Children’s Pavilion for Women. It will be one of only a handful of programs in the United States dedicated to the care and treatment of women’s reproductive mental health issues. The services offered will range from premenstrual dysphoric disorder, prenatal evaluation and treatment, postpartum mental health care, perimenopausal and menopausal mental health conditions. Texas Children’s identified these services as a foundation for our women’s health strategies in our community -- as healthy women lead to healthy families. The program has started with .5 FTE Reproductive Psychiatrist providing clinical services.

According to the Mental Health Report conducted by the World Health Organization, depression affects nearly 121 million people worldwide each year and is the fourth leading contributor to the global burden of disease. Of these cases, 850,000 result in tragic fatalities via means of suicide annually and fewer than 25% of those affected have access to effective treatments. In the United States alone, major depressive disorder affects about 14.8 million adults or 6.7% of the population age 18 and older within a given year. American women are two times more likely

---

16 World Health Organization. Mental health: Depression. 

17 National Institute of Mental Health. The numbers count: Mental disorders in America. 
to experience depression than men and depression is considered to be the leading cause of disease-related disability among women today.\(^\text{18}\)

While researchers continue to explore the reasons for women’s increased risk for depression over men, studies have shown that changes in hormone levels directly affect brain chemistry, a significant factor contributing to depressive disorders. Women during pregnancy and after delivery of their infants are particularly vulnerable to depression due to the rapid decline in estrogen and progesterone\(^\text{19}\), as well as the new responsibility of caring for a newborn.\(^\text{1}\) In fact, epidemiologic studies have demonstrated that women are more likely to be admitted to a psychiatric unit after giving birth than at any other time in their lives.\(^\text{20}\)

Approximately 13-15% of new mothers are diagnosed with Postpartum Depression (PPD).\(^\text{9}\) The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) defines PPD as a nonpsychotic, major depressive disorder with a specifier of postpartum onset within 4 weeks after childbirth.\(^\text{21}\) Among younger and socioeconomically disadvantaged mothers, the prevalence is even higher: about 1 in 4 women.\(^\text{22}\) Other risk factors for developing PPD include a history of depression, experience of depression or anxiety during the pregnancy, or a family history of psychiatric illness.\(^\text{23, 24, 25}\) Also, a woman’s relationship with her partner can be a predictive variable for PPD; women that are less satisfied, have higher levels of conflict, and receive less support from their partners are potentially at greater risk for PPD.\(^\text{9}\)

To have a diagnosis of PPD, a woman must present with depressed mood or loss of interest or pleasure in daily activities that represents a change in normal behavior and impairs everyday functioning for a minimum time frame of two weeks.\(^\text{6}\) Additionally, four of the following symptoms must also be present in order to constitute a diagnosis of PPD: weight change in absence of dieting, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or guilt, decreased ability to think or concentrate, and recurrent thoughts of death or suicide.\(^\text{6}\)

Once PPD has been identified, immediate treatment is essential. Patients that are not treated promptly are at risk for a longer duration of the illness which can lead to impaired functioning, refusal of treatment, prolonged symptoms, and suicide. Evidence-based treatment options that

---

have been shown effective include focused psychotherapy, antidepressants, or a combination approach.\textsuperscript{26} In 2011, Harris County had 69,896 births alone, at a minimum 6,900 of those women would benefit from treatment just during the postpartum period.

**Project Components:** Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

a. Conduct specialty care gap assessment based on community need for subspecialty.
b. Implement transparent standardized referrals across the system.
c. Increase specialty care volume of visits and evidence of improved access for patients seeking services.
d. Increase service availability hours and increase number of specialty clinic locations.
e. Conduct quality improvement for projects to improve access and learning collaborative exchanges.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For women with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective mental health care and in securing a comprehensive medical home.\textsuperscript{27}

**Milestones and Metrics**
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted women’s mental health population.

- Process milestone and metrics: P-1 (P-1.1); P-6, (P-6.1), P-21 (P-21.1)
- Improvement milestones and metrics: I-23 (I-23.1); I-33 (I-33.1)

Customizable Improvement Milestone and Metric was chosen in order to specifically tailor the intent of project to the targeted women’s mental health population.

**Unique community need identification number the project addresses:**
- CN.2: Inadequate access to specialty care,
- CN.6: Inadequate access to treatment and services designed for women.
- CN15: Insufficient access to services for pregnant women, particularly low income women
- CN18: Insufficient access to integrated care programs for behavioral health and physical health conditions

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This initiative in women’s mental health will allow us to provide a comprehensive program that creates resources, for this patient population, that is currently limited in Houston. Increasing access, will allow us to diagnosis women quicker which will enhance their quality of life. Educating and training obstetricians and pediatricians to improve screening in post-partum depression, to understand the challenges of psychiatric medications during pregnancy and


breastfeeding, and to understand the mental health needs of menopausal women will significantly enhance the quality of care women receive and allow us to collaboratively identify the most appropriate mental health services a women may need.

**Related Category 3 Outcome Measure(s):**
- OD-1 Primary Care and Chronic Disease Management
- IT-1.1 Third next available appointment
- OD-10 Quality of Life/Functional Status
- IT-10.1 Quality of Life

**Reasons/rationale for selecting the outcome measures:**
Our project will increase appropriate and timely access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in women and children and reduction in unnecessary health care costs.\(^\text{28}\)

**Relationship to other Projects:** All of Texas Children’s projects are working to expand access to subspecialty care for the women’s mental health population. This project focuses on expanding access to women’s reproductive mental health. Texas Children’s is investing in women’s health services as one of the best ways to truly impact children’s health by starting before conception and supporting maternal mental health after delivery. These interventions have a major impact on the mental and physical health of the child.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:** This project will compliment other projects designed to improve appropriate access to specialty care, improve chronic care management, and those designed to improve the patient experience. We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region’s health care system.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

**Project Valuation:** This project’s value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to

reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation also includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.


<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 (P-1):</strong> Conduct specialty care gap assessment to determine barriers to accessing subspecialty care</td>
<td><strong>Milestone 3 (P-6):</strong> Development and implement standardized referral and work-up guidelines</td>
<td><strong>Milestone 5 (I-23):</strong> Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td><strong>Milestone 8 (I-23):</strong> Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.</td>
</tr>
<tr>
<td>Metric 1 P-1.1 Documentation of gap assessment</td>
<td>Metric 1(P-6.1) Referral and Work-Up Guidelines</td>
<td>Metric 1 (I-23.1): Documentation of increased number of visits.</td>
<td>Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12).</td>
</tr>
<tr>
<td>Data Source: Gap Assessment Goal: Survey providers regarding access to mental health services and barriers of accessing subspecialty care Milestone 1 Estimated Incentive Payment: $268,593</td>
<td>a. Documentation of referral and work-up guidelines</td>
<td>a. Total number of visits for reporting period</td>
<td>a. Total number of visits for reporting period</td>
</tr>
<tr>
<td><strong>Milestone 2 (P-21):</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td><strong>Milestone 4 (P-21):</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td><strong>Milestone 6 (I-29):</strong> Increase the number of referrals of targeted patients to the specialty care clinic.</td>
<td><strong>Milestone 9 (I-29):</strong> Increase the number of referrals of targeted patients to the specialty care clinic.</td>
</tr>
<tr>
<td>Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</td>
<td></td>
<td>Metric 1 (I-29.1) Targeted referral rate</td>
<td>Metric 1 (I-29.1) Targeted referral rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a.) Number of referrals of targeted patients</td>
<td>a.) Number of referrals of targeted patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b.) Data Source: Epic EHR, Paper Documentation Goal: 100 Referrals of targeted patients</td>
<td>b.) Data Source: Epic EHR, Paper Documentation Goal: 200 Referrals of targeted patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Milestone 6 Estimated Incentive</td>
<td>Milestone 9 Estimated Incentive</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>139135109.3.42</td>
<td>TX-10.1</td>
<td>IT-1.1</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>----------------</td>
<td>---------</td>
<td>--------</td>
</tr>
</tbody>
</table>
| **Year 2** (10/1/2012 – 9/30/2013)    | Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $268,593 | improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $293,020.50 | Payment: $195,915 | **Milestone 7 [P-21]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 7 Estimated Incentive Payment: $195,915 | **Milestone 10 [P-21]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 10 Estimated Incentive Payment: $161,842.67 | **Regional Healthcare Partnership Plan** Region 3 **830**
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Texas Children’s Hospital</th>
<th>139135109</th>
</tr>
</thead>
</table>

### Year 2 (10/1/2012 – 9/30/2013)

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Texas Children’s Hospital</th>
<th>139135109</th>
</tr>
</thead>
</table>

### Year 2 Estimated Milestone Bundle Amount:
- $537,186

### Year 3 (10/1/2013 – 9/30/2014)

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Texas Children’s Hospital</th>
<th>139135109</th>
</tr>
</thead>
</table>

### Year 3 Estimated Milestone Bundle Amount:
- $586,041

### Year 4 (10/1/2014 – 9/30/2015)

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Texas Children’s Hospital</th>
<th>139135109</th>
</tr>
</thead>
</table>

### Year 4 Estimated Milestone Bundle Amount:
- $587,745

### Year 5 (10/1/2015 – 9/30/2016)

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Texas Children’s Hospital</th>
<th>139135109</th>
</tr>
</thead>
</table>

### Year 5 Estimated Milestone Bundle Amount:
- $485,528

### Payment:
- Year 2: $161,842.67
- Year 3: $242,764
- Year 4: $537,186
- Year 5: $587,745

### TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):
- $2,196,500
The University of Texas Health Science Center - Houston
Pass 1
Project Option 1.1.2 - 1.1 Expand Primary Care Capacity: Expand Existing Primary Care Capacity at UT Physicians Clinics

**Unique RHP Project ID:** 111810101.1.1

**Performing Provider Name/TPI:** UTHealth, UTPhysicians / 111810101

**Project Summary:**

Provider: UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

**Intervention(s):** UT Physicians will expand primary care capacity at each of its 4 outlying clinics. Space will be acquired for additional consulting, exam and procedure rooms. Additional providers and support staff will be added to provide primary care services, and the hours of service will be extended, including evenings and Saturdays.

**Need for the project:** This project addresses the county’s inadequate access to primary care and high rates of inappropriate emergency department utilization. For the fiscal year 2010, 10% of all potentially preventable hospitalizations (PPR) were ambulatory care sensitive. In 2009, 41% (390,945) of ED visits in Houston were primary care related (PCR), including non-urgent, primary care treatable, and primary care preventable, and for 26.8% (104,762) of these PCR visits, Medicaid was the payer.

**Target Population:** The service areas of our 4 outlying clinics include large populations with economic, cultural, language, and transportation barriers to receiving primary care. Using the Harris County rate (14.5%) of Medicaid clients, there are an estimated 1,423,176 Medicaid clients living within the service areas of the UT Physician Clinics.

**Category 1 or 2 expected patient benefits:**
Our goal is to increase primary care clinic visits and improve access for patients seeking services. This will translate to better patient satisfaction with primary care services. By expanding primary capacity at our community clinics, we expect to deliver a total of **36,458** patient visits by the end of DY5. At our current payer mix of 23% Medicaid, at least **8,385** of these would be Medicaid visits. However, this is a very conservative estimate, since all our expansion projects are targeting the low income populations in our service areas that are either on Medicaid, or are Medicaid-eligible.

**Category 3 outcomes:**
Our goals are to reduce the impact of cancer by increasing early detection screenings for cervical cancer (IT-12.2), breast cancer (IT-12.1), and colorectal cancer (IT-12.3).
Project Option 1.1.2 – Expand Primary Care Capacity: Expand Existing Primary Care Capacity at UT Physicians Clinics

Unique RHP Project Identification Number:  111810101.1.1
Performing Provider Name/TPI:  UTHealth, UTPhysicians/111810101

Project Description:  1.1 Expand Primary Care Capacity (Option 1.1.2)

UT Physicians (UTP) will expand primary care capacity at each of its 4 outlying (outside the Texas Medical Center) clinics. UTP has defined the service area for its clinics to include the census tracts within a seven-mile radius of each clinic. The Bayshore Clinic is in the southeast area of Houston and includes parts of Pasadena, South Houston, and areas immediate south of the ship channel. The service area of this clinic has a population of 431,199, with 36.5% living at/below the federal poverty level (FPL). The population is 49.2% Hispanic and of those, 51.1% are not proficient in English. The Bellaire Clinic, with a population of 472,698, is on the west side of Houston and also has a large minority population, with 24.1% Black/African American and 46% Hispanic, and 52.2% live at/below the FPL. Of the Spanish-speaking population in the Bellaire Clinic service area, 62.8% are not proficient in English. The Cinco Ranch (population 287,744) and Sienna Village (population 231,535) clinics serve populations reaching into Ft. Bend County that closely mirror the overall county demographics, with the exception of Sienna Village Clinic, which has a large Black/African American population of 33.5%. There are 20.8% of the Cinco Ranch Clinic population and 26.2% of the Sienna Village Clinic population living at/below the FPL. These two clinics also serve rural populations. The service areas of these 4 clinics include large populations with economic, cultural, language, and transportation barriers to receiving primary care. Using the Harris County rate (14.5%) of Medicaid clients, there are an estimated 1,423,176 Medicaid clients living within the service areas of the UT Physician Clinics. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties. The Medicaid rate is from the U.S. Census Bureau and the Centers for Disease Control and Prevention, State and County by Demographic and Income Characteristics. SAHIE, 2009.)

Additional space will be purchased to expand UT Physicians’ Clinics. This will include additional consulting, exam and procedure rooms. Additional providers will be added to provide primary care services, support staff will be increased to accommodate the additional providers and increased patient load, and the hours of service will also be extended, including additional evening hours and Saturdays. With a minimum of one additional primary care provider and related support staff at each of the 4 clinics, there is the potential for 16,800 additional primary care contacts per year using the HRSA physician productivity target.

Goal and Relationship to Regional Goals:

Project Goals:
Expand primary care capacity to better accommodate the needs of the regional patient population and community, so that patients have enhanced access to the right health care services, at the right time, in the right setting.

This project addresses the following regional goals:
One of the goals of the region is to "Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay". Expansion of primary care capacity certainly relates to this goal as it will make it easier for UT Physicians to provide care to underserved populations.

**Challenges:**

Need: 1) Inadequate access to primary care. 2) High rates of inappropriate emergency department utilization.

Implementation: 1) Staff recruitment and retention. 2) Marketing of expansion.

By expanding the capacity of their clinics, UT Physicians will be better able to deliver timely care to more patients when needed thereby diverting patients away from the emergency room. UT Physicians will recruit physicians from the UTHealth residents placed at Memorial Hermann Hospital-TMC and will offer them a competitive salary and other incentives to practice in the outlying clinics. A marketing campaign that addresses the culture(s) and needs of the community will be implemented to inform the community of our expanded capacity to provide quality care that is convenient for them.

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

There will be shortening of waiting times for primary care appointments and increased uptake of primary care services in our service areas, which will increase the percentage of patients who receive regular screenings for breast cancer and colon cancer. Detecting cancer early can reduce the burden of the disease in terms of both improved health outcomes and lower costs. In addition to benefiting the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base of UTP clinics, the expansion of services will be marketed to the additional 1,423,176 Medicaid and Medicaid-eligible residents living within the service areas of the UT Physician Clinics. The expansion of service hours to nights and Saturdays will be of particular benefit to those unable to see a physician during business hours. The increase in primary care capacity, coupled with our transition to the team-based, proactive healthcare delivery model of medical homes, all conveniently located where there is great need, will help to address many of the barriers that the low-income population typically encounter in getting the appropriate care, facilitating better health outcomes.

By expanding primary capacity at our community clinics, we expect to deliver a total of 36,458 patient visits by the end of DY5. At our current payer mix of 23% Medicaid, at least 8,385 of these would be Medicaid visits. However, this is a very conservative estimate, since all our expansion projects are targeting the low income populations in our service areas that are either on Medicaid, or are Medicaid-eligible.

**Starting Point/Baseline:**

This is a new program. Consequently our baseline is zero. The targets for our milestones and metrics are based upon the planned expanded capacity of the clinic.

**Rationale:**

Research has shown that access to primary care is associated with better health outcomes at less cost. Access to primary care ensures better preventive care and better management of chronic disease; on the other hand lack of access often results in more expensive care, received
in hospitals and emergency departments (ED). For the fiscal year 2010, 10% of all potentially preventable readmissions (PPR) were ambulatory care sensitive. In 2009, 41% (390,945) of ED visits in Houston were primary care related (PCR), including non-urgent, primary care treatable, and primary care preventable, and for 26.8% (104,762) of these PCR visits, Medicaid was the payor. Getting more patients into primary care will help to reduce the use of this more costly care. Placing more primary care providers out in the communities served by the UT Physicians will help to address transportation access barriers and the expansion of clinic service hours will provide a greater selection of available appointment times. By increasing primary care capacity and engaging more people in the primary care system, avoiding inappropriate utilization of costly services, the community will experience better health outcomes and greater patient satisfaction. (PPR rate was from the Texas Health and Human Services Commission report on Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal year 2010, published January, 2012. The statistics for ED use were from the Houston Hospitals Emergency Department Use Study (January 1, 2009 through December 31, 2009), Final Report, prepared by the UT School of Public Health, May 2011, included in the 2010 Harris County Community Needs Assessment for Memorial Hermann.)

**Project Components:**

As part of the program to Expand Existing Primary Care Capacity at UT Physicians Clinics, we propose to meet all required project components listed below:

a) UTP will identify and purchase/lease additional primary care clinic space to include additional consulting, exam and procedure rooms.

b) UTP will recruit additional primary care providers and support staff to implement the expansion.

c) The hours of UTP clinics will be expanded to include evening and Saturday hours.

**Milestones and Metrics:**

For the Expand Existing Primary Care Capacity at UT Physicians Clinics Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

**Process Milestones and Metrics:**

- **Milestone 1 [P-1]:** Expand existing primary care clinics
  - Metric 1 [P-1.1]: Amount of additional space acquired to expand clinic services.

- **Milestone 2 [P-5]:** Hire additional primary care providers and necessary support staff
  - Metric 1 [P-5.1]: Documentation of increased number of providers and staff (for DY2).

- **Milestone 3 [P-5]:** Hire additional primary care providers and necessary support staff
  - Metric 1 [P-5.1]: Documentation of increased number of providers and staff (for DY3).

- **Milestone 4 [P-4]:** Expand the hours of primary care clinics, including evening and weekend hours
  - Metric 1 [P-4.1]: Increased number of hours at primary care clinics (for DY3) over prior reporting period.

- **Milestone 6 [P-4]:** Expand the hours of a primary care clinics, including evening and/or weekend hours
  - Metric 1 [P-4.1]: Increased number of hours at primary care clinics (for DY4) over prior reporting period.
Milestone 7 [P-X1]: Participate in a learning collaborative
   Metric 1 [P-X1.1]: Participate in face-to-face meetings or seminars organized by the RHP.

Milestone 11 [P-X2]: Conduct a needs/gap analysis, in order to inform the establishment or expansion of services/programs
   Metric 1 [P-X2.1]: Completion of a gap assessment report on primary care unmet needs in our service areas to inform the next phase of planning.

Improvement Milestones and Metrics:
Milestone 5 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.
   Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (DY2).

Milestone 8 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.
   Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (DY3).

Milestone 9 [I-11]: Patient satisfaction with primary care services.
   Metric 1 [I-11.1]: Improved Patient satisfaction scores

Milestone 10 [I-11]: Patient satisfaction with primary care services.
   Metric 3 [I-11.3]: Survey response rate. Demonstrate improvement over prior reporting period.

Milestone 12 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.
   Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (DY4).

Unique community need identification numbers the project addresses:
   This project addresses community needs CN.1 (Inadequate access to primary care) and CN.8 (High rates of inappropriate emergency department utilization).

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
   UT Physicians operates 4 clinics that serve areas that include large populations with economic, cultural, language, and transportation barriers to receiving primary care. This project proposes to add space, providers, support staff, and extend service hours to include evenings and weekends at these locations where the demand for services is high. This project is an expansion of services in order to improve access to care.

Related Category 3 Outcome Measure(s):
OD-12 Primary Care and Primary Prevention
   • IT-12.2 Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)
     Numerator: Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years.
     Denominator: Women aged 21 to 64 in the patient or target population.
     Women who have had a complete hysterectomy with no residual cervix are excluded.
• IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)
  Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period. Denominator: Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded.

OD-12 Primary Care and Primary Prevention
• IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)
  Numerator: Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years
  Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.

Relationship to other Projects:
1.2 (A2, SPH1) - Increased training of primary care workforce will provide physicians and support staff needed to expand primary care capacity.
1.7 (A1) - Expanded primary care capacity will facilitate and enhance access to specialty care via telemedicine.
1.10 (MS1) - The systems engineering and user dashboards will give providers greater access to information and provide reports facilitating a continuous quality improvement process.
2.1 (C1-2) - As part of the medical home project, all patients will be assigned to a primary care provider within the UT Health medical home. Expanded primary care capacity will be a necessary step to making this possible.
2.2 (CL3, C5-C9) - Expanded capacity in primary care will ensure the availability of staff to implement the expansion of the chronic care management model for the targeted diseases.
2.11 (C10) - The medication management program will be an integral part of the coordinated care provided by the primary care physicians.
2.12 (A3, CL1, CL2, MS4) - For the various care transition projects to be succesful, UT Health needs to ensure it has adequate primary care capacity to handle the increased volume of patients.

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

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

**Project Valuation:**
The anchor, Harris Health, provided a spreadsheet that contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criterion, and the reasons two of the criteria were not used:

1. **Transformational Impact** (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. **Population Served/Project Size** (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.

3. **Aligned with Community Needs** (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. **Cost Avoidance** (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects

5. **Partnership/Collaboration** (Weight = 10%): *This was not rated*, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. **Sustainability** (Weight = 15%): *This was also not rated*, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criterion again would have had a diluting effect, hiding the more significant variations in other value criteria.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Expand Existing Primary Care Capacity at UT Physicians Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>111810101.1.1</td>
<td>UTHealth, UTPhysicians</td>
</tr>
<tr>
<td>111810101.3.1</td>
<td>Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)</td>
</tr>
<tr>
<td>111810101.3.2</td>
<td>Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)</td>
</tr>
<tr>
<td>111810101.3.3</td>
<td>Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)</td>
</tr>
</tbody>
</table>

**Year 2** (10/1/2012 – 9/30/2013)

**Milestone 1 [P-1]: Expand existing primary care clinics**

**Metric 1 [P-1.1]:** Amount of additional space acquired to expand clinic services.
- **Goal:** We will acquire 4 physician offices and 12 exam rooms.
- **Data Source:** New primary care schedule and other UT Physicians' documents.
- **Milestone 1 Estimated incentive payment:** $2,281,182

**Milestone 2 [P-5]:** Hire additional primary care providers and support staff

**Metric 1 [P-5.1]:** Documentation of increased number of providers and support staff.
- **Baseline/Goal:** 2 primary care providers, 3 support personnel.
- **Data Source:** UT Physicians' report, policy, contract or other documentation.
- **Milestone 3 Estimated incentive payment:** $1,642,497

**Milestone 3 [P-5]:** Hire additional primary care providers and necessary support staff

**Metric 1 [P-5.1]:** Documentation of increased number of providers and staff.
- **Baseline/Goal:** 2 primary care providers, 3 support personnel.
- **Data Source:** UT Physicians' report, policy, contract or other documentation.

**Year 3** (10/1/2013 – 9/30/2014)

**Milestone 4 [P-4]:** Expand the hours of a primary care clinic, including evenings and/or weekend hours

**Metric 1 [P-4.1]:** Increased number of hours at primary care clinic over prior reporting period.
- **Baseline/Goal:** Cinco to add Saturday (4hrs); Bellaire to add evening hours (3hrs); Sienna to add 2 evening hours (6hrs); Bayshore to add 1 evening hour (3hrs).
- **Data Source:** Clinic documentation.
- **Milestone 6 Estimated incentive payment:** $1,849,909

**Milestone 6 [P-4]:** Expand the hours of a primary care clinic, including evenings and/or weekend hours

**Metric 1 [P-4.1]:** Increased number of hours at primary care clinic over prior reporting period.
- **Baseline/Goal:** Cinco to add Saturday (4hrs); Bellaire to add evening hours (3hrs); Sienna to add 2 evening hours (6hrs); Bayshore to add 1 evening hour (3hrs).
- **Data Source:** Clinic documentation.

**Year 4** (10/1/2014 – 9/30/2015)

**Milestone 7 [P-X1]:** Participate in a learning collaborative

**Metric 1 [P-X1.1]:** Participate in face-to-face meetings or seminars organized by the RHP.
- **Goal:** At least 2 per year.
- **Data Source:** Documentation of meetings including meeting agendas, slides from presentations, and/or meeting notes.
- **Milestone 7 Estimated incentive payment:** $1,849,909

**Milestone 8 [P-X1]:** Participate in a learning collaborative

**Metric 1 [P-X1.1]:** Participate in face-to-face meetings or seminars organized by the RHP.
- **Goal:** At least 2 per year.
- **Data Source:** Documentation of meetings including meeting agendas, slides from presentations, and/or meeting notes.

**Year 5** (10/1/2015 – 9/30/2016)

**Milestone 9 [I-11]:** Patient’s satisfaction with primary care services.

**Metric 1 [I-11.1]:** Improved Patient satisfaction scores
- **Baseline:** Overall Mean Score is 87.6;
- **Ability to get appointment when wanted is 82.7**
- **Goal:** A statistically significant increase at the 95% level in both the overall mean score for patient satisfaction and in the score for ability to get appointment when wanted.
- **Data Source:** CG-CAHPS3 or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population.
- **Milestone 9 Estimated incentive payment:** $1,285,401

**Milestone 10 [I-11]:** Patient satisfaction with primary care services.

**Metric 3 [I-11.3]:** Survey response rate. Demonstrate improvement over prior reporting period.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>EXPAND EXISTING PRIMARY CARE CAPACITY AT UT PHYSICIANS CLINICS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OPTION 1.1.2</strong></td>
<td><strong>1.1.2 (A-C)</strong></td>
<td><strong>UTHealth, UTPhysicians</strong></td>
</tr>
<tr>
<td><strong>111810101.1.1</strong></td>
<td><strong>IT-12.2</strong></td>
<td><strong>Baseline: 21.43% (2012)</strong></td>
</tr>
<tr>
<td><strong>111810101.3.1</strong></td>
<td><strong>IT-12.1</strong></td>
<td><strong>Goal: A statistically significant increase in the response rate at the 95% level.</strong></td>
</tr>
<tr>
<td><strong>111810101.3.2</strong></td>
<td><strong>IT-12.3</strong></td>
<td>Data Source: CAHPS or other developed evidence based satisfaction assessment tool; Performing provider documentation of survey distribution, EHR</td>
</tr>
<tr>
<td><strong>111810101.3.3</strong></td>
<td></td>
<td>Milestone 5 Estimated incentive payment: $1,285,400</td>
</tr>
</tbody>
</table>

**Year 2**  
(10/1/2012 – 9/30/2013)  
**Milestone 4** Estimated incentive payment: $1,642,497

**Milestone 5 [I-12]**: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1 [I-12.1]**: Documentation of increased number of visits. Demonstrate improvement over baseline (new clinic).
Goal: Increase volume of primary care visits by 7,277 over baseline.
Data Source: Registry, EHR, claims or other UT Physicians' source

**Milestone 5 Estimated incentive payment: $1,642,497**

**Year 3**  
(10/1/2013 – 9/30/2014)  
**Milestone 8** Estimated incentive payment: $1,849,908

**Milestone 8 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.**

**Metric 1 [I-12.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period.
Goal: Increase volume of primary care visits by 6,785 over prior reporting period, for a total of 14,062 additional primary care visits this year.
Data Source: Registry, EHR, claims or other UT Physicians' source

**Milestone 8 Estimated incentive payment: $1,849,908**

**Year 4**  
(10/1/2014 – 9/30/2015)  
**Milestone 10** Estimated incentive payment: $1,285,400

**Milestone 10 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.**

**Metric 1 [I-12.1]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period.
Goal: Increase volume of primary care visits by 6,785 over prior reporting period, for a total of 14,062 additional primary care visits this year.
Data Source: Registry, EHR, claims or other UT Physicians' source

**Milestone 10 Estimated incentive payment: $1,285,400**

**Year 5**  
(10/1/2015 – 9/30/2016)  
**Milestone 11** Estimated incentive payment: $1,285,400

**Milestone 11 [P-X2]: Conduct a needs/gap analysis, in order to inform the establishment or expansion of services/programs**

**Metric 1 [P-X2.1]:** Completion of a gap assessment report on primary care unmet needs in our service areas to inform the next phase of planning.
Goal: Complete gap assessment report to assess unmet needs and opportunities to further expand primary care services.
Data Source: Gap assessment report.

**Milestone 11 Estimated incentive payment: $1,285,400**

**Milestone 12 [I-12]: Increase primary**
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>111810101.3.1</th>
<th>111810101.3.2</th>
<th>111810101.3.3</th>
<th>1.1.2 (A-C)</th>
<th>EXPAND EXISTING PRIMARY CARE CAPACITY AT UT PHYSICIANS CLINICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)</td>
<td>IT-12.2</td>
<td>IT-12.1</td>
<td>IT-12.3</td>
<td>UTHealth, UTPhysicians</td>
<td>111810101</td>
</tr>
<tr>
<td>Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2**
(10/1/2012 – 9/30/2013)

- Year 2 Estimated Milestone Bundle Amount: $4,562,364

**Year 3**
(10/1/2013 – 9/30/2014)

- Year 3 Estimated Milestone Bundle Amount: $4,927,491

**Year 4**
(10/1/2014 – 9/30/2015)

- Year 4 Estimated Milestone Bundle Amount: $5,549,726

**Year 5**
(10/1/2015 – 9/30/2016)

- Year 5 Estimated Milestone Bundle Amount: $5,141,601

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $20,181,182
Project Option 1.2.1- 1.2 Increase Training of Primary Care Workforce: UT Health Regional Academy for Translational Medicine and UT Health Academy for Patient Quality and Safety

Unique RHP Project ID: 111810101.1.2
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider: UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s): This innovative program will train residents in the "new primary care" model that is capable of staffing "enhanced medical homes." The training program for health care providers will be updated to lay emphasis on team-based practice, quality and cost control. Faculty staff at UT Health will be trained to implement the new residency program.

Need for the project: In addition to the overall shortage of primary care physicians in the region and Texas as a whole, the current curriculum used in residency training needs to be updated by emphasizing the importance of team based care, care coordination and the central role of the patient in achieving desirable health outcomes and controlling costs.

Target Population: All patients within the greater Houston area and beyond who will potentially benefit from new cohorts of physicians trained in delivering quality evidence-based care. The immediate beneficiaries of this project are the patients population of the UTP Bayshore Clinic.

Category 1 or 2 expected patient benefits: Approximately 21,600 continuity clinic sessions will be completed by residents by the end of DY5, with a minimum of 5,000 of these being with patients on Medicaid, or who are Medicaid eligible. The 15 residents trained through this program will go on to produce approximately 63,000 patient visits each year.

Category 3 outcomes:
IT – 14.6 Percent of trainees who have spent at least 5 years living in a healthprofessional shortage area (HPSA) or medically underserved area (MUA)
IT- 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey
IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey
Project Option 1.2.1 – Increase Training of Primary Care Workforce: UT Health Regional Academy for Translational Medicine and UT Health Academy for Patient Quality and Safety

Unique RHP Project Identification Number: 111810101.1.2
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 1.2 Increase Training of Primary Care Workforce (Option 1.2.1)

In addition to the overall shortage of primary care physicians in the region and Texas as a whole, the current curriculum used in residency training needs to be updated by emphasizing the importance of team-based care, care coordination and the central role of the patient in achieving good health outcomes and controlling costs. To transform primary care in the region, there is a need to train a generation of physicians that will embrace the concepts of the patient-centered medical home (PCMH) practice, cost control, and place emphasis on quality improvement in their practice.

An innovative residency program in translational medicine will be developed and implemented by the UT Health Regional Academy for Translational Medicine. This innovative program, linked to new scholarly concentration(s), will train residents in the "new primary care" in Texas and the United States capable of staffing "enhanced medical homes." Also, the UT Health Academy for Patient Quality and Safety will operate a structured educational training for health care providers with emphasis on team-based practice, quality and cost control. These training programs will update the current model of training for primary care physicians by including training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and quality/performance improvement. Faculty and staff at UT Health (including family medicine, internal medicine, obstetrics and gynecology, geriatrics, and pediatrics) will be trained to implement the new residency training.

Goal and Relationship to Regional Goals:

Project Goal:

To update primary care training programs to include organized care delivery models, with an emphasis on team-based practice, quality and cost control.

This project addresses the following regional goals:

Among the goals of the region is to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system". By reorienting the education of physicians, this project will produce a new generation of physicians that better appreciate the importance of team care, patient focus, and role of care coordination in achieving satisfactory outcomes.

Challenges:

Need: 1) Shortage of primary care physicians trained in team-based models of care, such as the medical homes model.
Implementation: 1) Training for the trainers. 2) Attracting physicians to primary care.
This project will ensure that physicians trained in family medicine, internal medicine, obstetrics and gynecology, geriatrics, and pediatrics will be prepared to deliver coordinated care in institutions using the "new primary care model" or medical home model, thereby giving the population access to care teams better suited to attend to their needs. Training for attending physicians will be provided as a part of UTHealth's transition to a medical home model of practice and the necessary support given during and after the transition by putting in place monitoring, quality control, and evaluation systems. Since the study of medical students reaction to their training showed that they valued training that better prepared them for this type of practice experience, we expect that this program will be attractive to future physicians.

5-Year Expected Outcome for Provider and Patients:

Our primary care residency programs will have been reoriented to a new primary care model, with faculty adequately prepared to train new primary care physicians on organized care delivery models that emphasize team-based practice, quality and cost control. The transition to this team-based, proactive healthcare delivery model will help to address many of the barriers that the low-income population typically encounter in getting the appropriate care, facilitating better health outcomes.

By instituting this new enhancement to primary care resident training, approximately 21,600 continuity clinic sessions will be completed by residents by the end of DY5, with a minimum of 5,000 of these being with patients on Medicaid, or who are Medicaid eligible. The 15 residents trained through this program will go on to produce approximately 63,000 patient visits each year.

Starting Point/Baseline:
This is a new program, so baselines are set at zero. Targets are set based upon projected capacity for the program.

Rationale:
It has been well-documented that our current system of care is fragmented, which leads to suboptimal performance, including unnecessary procedures, safety problems, avoidable complications and costs, and the available care can vary greatly in both quantity and quality (Swensen SJ, et al. Cottage Industry to Postindustrial Care — The Revolution in Health Care Delivery. February 4, 2010. N Engl J Med, 362(5);e12). In order to move closer to a well-functioning health care delivery system, providers must have training that prepares them for the coordinated, outcomes- and evidence-based health care systems they will be entering. A recent nation-wide study conducted with medical students found that students felt their training was appropriate in terms of clinical decision making and clinical care, but felt that their training had not prepared them appropriately for practicing medicine (Patel MS, Davis MM, Lypson ML. Medical Student Perceptions of Education in Health Care Systems. September, 2009. Academic Medicine, 84(9):1301-6).

Project Components:
Through the UT Health Regional Academy for Translational Medicine and UT Health Academy for Patient Quality and Safety Program, we propose to meet all required project components listed below.

1) UT Health will enlist/recruit faculty for the development of the new primary care residency program.
2) Faculty will be trained in the new primary care medical home model.
3) The new primary care training program will provide resident training on:
   a) medical homes,
   b) chronic care models,
   c) disease registry use for population health management,
   d) patient panel management,
   e) oral health, and
   f) quality/performance improvement
4) UT Physicians’ Bayshore clinic will provide the continuity clinics for the new residency program.

Milestones and Metrics:
For the UT Health Regional Academy for Translational Medicine and UT Health Academy for Patient Quality and Safety Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY3.

Process Milestones and Metrics:

Milestone 1 [P-8]: Establish/expand a faculty development program
Metric 1 [P-8.1]: Enrollment of faculty/staff into primary care education and training program

Milestone 2 [P-3]: Expand positive primary care exposure for residents/trainees
Metric 1 [P-3.1]: Develop mentoring program with primary care faculty and new trainees

Milestone 3 [P-9]: Develop/disseminate clinical teaching tools for primary care or interdisciplinary clinics/sites
Metric 1 [P-9.1]: Clinical teaching tools

Milestone 4 [P-3]: Expand positive primary care exposure for residents/trainees
Metric 1 [P-3.2]: Train trainees in the medical home model, chronic Care Model and/or disease registry use; have primary care trainees participate in medical homes by managing panels (DY3).

Milestone 5 [P-4]: Develop and implement a curriculum for residents to use their practice data to demonstrate skills in quality assessment and improvement
Metric 1 [P-4.1]: Quality assessment and improvement practicum for residents

Milestone 6 [P-3]: Include trainees/rotations in quality improvement projects
Metric 1 [P-3.3]: Include trainees/rotations in quality improvement projects

Milestone 7 [P-3]: Include trainees/rotations in quality improvement projects
Metric 1 [P-3.2]: Train trainees in the medical home model, chronic Care Model and/or disease registry use; have primary care trainees participate in medical homes by managing panels (DY4).

Milestone 8 [P-3]: Expand positive primary care exposure for residents/trainees
Metric 1 [P-3.3]: Include trainees/rotations in quality improvement projects

Milestone 9 [P-3]: Include trainees/rotations in quality improvement projects
Metric 1 [P-3.2]: Train trainees in the medical home model, chronic Care Model and/or disease registry use; have primary care trainees participate in medical homes by managing panels (DY5).

Improvement Milestones and Metrics:

Milestone 6 [I-14]: Increase the number of faculty staff completing educational courses
Metric 1 [I-14.1]: Number of staff completing courses
**Milestone 9 [I-15]:** Increase primary care training in Continuity Clinics, which may be in diverse, low-income, community-based settings.

**Metric 1 [I-15.1]:** Increase number of Continuity Clinic sessions available for primary care trainees.

**Unique community need identification numbers the project addresses:**
This project addresses community needs CN.16 (Shortage of primary and specialty care physicians), CN.25 (Graduate medical education, residency training, in health care systems, team-based practice, quality improvement, and cost control), CN.7 (Insufficient access to care coordination practice management and integrated care treatment programs), and CN.24 (Lack of care coordination and unnecessary duplication of services due to insufficient implementation and use of electronic health records).

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This is a new initiative. The current residency program does not include training for residents on health care systems, patient-centered team-based practice, quality improvement, and cost control.

**Related Category 3 Outcome Measure(s):**
**OD-14 Workforce Development**
- IT - 14.6 Percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA)
- IT - 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey
- IT - 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

**Relationship to other Projects:**
1.1 (C3) - Increased training of workforce competent to staff the 'new primary care' model will facilitate the recruitment of providers for expansion of primary care capacity.
1.3 (C12) - Part of the innovative training of primary care providers will be centered on the role of chronic disease management, for which the registries are essential.
1.7 (A1) - Enhanced training will include education on telemedicine as a cost-effective alternative to the more traditional face-to-face access to specialty medical care consults.
2.1 (C1-2) - Increased training of workforce competent to staff the 'new primary care' model will facilitate the recruitment of providers ready to practice in a medical home setting.
2.2 (C5-9,CL3) - Part of the innovative training of primary care providers will be centered on the chronic care model, with emphasis on team-based practice.
2.11 (C10) - Structured educational training for health care providers on quality and cost control will entail instruction in medication therapy management for minimizing medication errors.

**Relationship to Other Performing Providers’ Projects in the RHP:**
Our region is blessed with multiple academic organizations that are a recruitment ground for areas that are currently medically underserved, but there is a drastic need of additional residency programs due to existing class size and training programs. The residency program
proposals will allow the organizations to benefit in workforce need for all other initiatives. There is a unique initiative in our region for the expansion of a residency program.

**Plan for Learning Collaborative:**

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

**Project Valuation:**

The anchor, Harris Health, provided a spreadsheet that contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criterion, and the reasons two of the criteria were not used:

1. **Transformational Impact** (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. **Population Served/Project Size** (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.

3. **Aligned with Community Needs** (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. **Cost Avoidance** (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects.

5. **Partnership/Collaboration** (Weight = 10%): *This was not rated*, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. **Sustainability** (Weight = 15%): *This was also not rated*, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>111810101.3</td>
<td>111810101.3.4</td>
<td>IT-14.6</td>
<td>Percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA) based on a systematic survey. Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey. Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey.</td>
<td></td>
</tr>
<tr>
<td>111810101.5</td>
<td>IT-14.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>111810101.6</td>
<td>IT-14.8</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Milestone 1 [P-8]: Establish/expand a faculty development program

**Metric 1 [P-8.1]**: Enrollment of faculty staff into primary care education and training program

Baseline: 0 (new program)

Goal: 3 faculty staff

Data Source: Program documents

Milestone 1 Estimated incentive payment: $ 838,115

Milestone 2 [P-3]: Expand positive primary care exposure for residents/trainees

**Metric 1 [P-3.1]**: Develop mentoring program with primary care faculty and new trainees

Baseline: None (new program)

Goal: Documentation of new program curriculum, participants

Data Source: Mentoring program curriculum and/or program participant list

Milestone 2 Estimated incentive payment: $ 870,338

Milestone 3 [P-9]: Develop/disseminate clinical teaching tools for primary care or interdisciplinary clinics/sites

**Metric 1 [P-9.1]**: Clinical teaching tools

Baseline: 0 (new program)

Goal: Disseminate new clinical teaching tools to faculty/mentors.

Data Source: Program documents and tools disseminated

Milestone 3 Estimated incentive payment: $ 870,338

Milestone 4 [P-3]: Expand positive primary care exposure for residents/trainees

**Metric 1 [P-3.2]**: Trainee in the medical home model, chronic Care Model and/or disease registry use; have primary care trainees participate in medical homes by managing panels

Baseline: None (new program)

Milestone 4 Estimated incentive payment: $ 655,368

Milestone 5 [P-4]: Develop and implement a curriculum for residents to use their practice data to demonstrate skills in quality assessment and improvement

**Metric 1 [P-4.1]**: Quality assessment and improvement practicum for residents

Baseline: None (new program)

Goal: Develop and implement QI practicum for residents

Data Source: Curriculum description and registration documentation

Milestone 5 Estimated incentive payment: $ 656,316

Milestone 6 [I-14]: Increase the number of faculty staff completing educational courses

**Metric 1 [I-14.1]**: Number of staff completing courses

Goal: 6 additional faculty staff

Data Source: Certificates of Milestone 6 Estimated incentive payment: $ 656,316

Milestone 8 [P-3]: Expand positive primary care exposure for residents/trainees

**Metric 1 [P-3.3]**: Include trainee/rotation in quality improvement projects

Baseline: None (new program)

Goal: 5

Data Source: Curriculum and/or quality improvement project documentation/data

Milestone 8 Estimated incentive payment: $ 656,316

Milestone 9 [I-15]: Increase primary care training in Continuity Clinics, which may be in diverse, low-income, community-based settings.

**Metric 1 [I-15.1]**: Increase number of Continuity Clinic sessions available for primary care trainees.

Goal: 6 per resident

Data Source: Number of trainee office
<table>
<thead>
<tr>
<th>111810101.1.2</th>
<th>OPTION 1.2.1</th>
<th>UT HEALTH REGIONAL ACADEMY FOR TRANSLATIONAL MEDICINE AND UT HEALTH ACADEMY FOR PATIENT QUALITY AND SAFETY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td><strong>IT-14.6</strong></td>
<td><strong>IT-14.7</strong></td>
</tr>
<tr>
<td>Percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA)</td>
<td>Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey</td>
<td>Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 2 Estimated incentive payment:</strong> $838,115</td>
<td>Goal: 5 new residents Data Source: Curriculum, rotation hours, and/or patient panels assigned to resident/trainee</td>
<td>completion or course graduate records. Milestone 6 Estimated incentive payment: $655,368</td>
<td>visits, such as from disease registry, EHR, claims data or other reports Milestone 9 Estimated incentive payment: $656,316</td>
</tr>
<tr>
<td><strong>Milestone 4 Estimated incentive payment:</strong> $870,337</td>
<td><strong>Milestone 7 [P-3]: Expand positive primary care exposure for residents/trainees</strong> Metric 1 [P-3.2]: Train trainees in the medical home model, chronic Care Model and/or disease registry use; have primary care trainees participate in medical homes by managing panels Baseline: None (new program) Goal: 5 new residents Data Source: Curriculum, rotation hours, and/or patient panels assigned to resident/trainee Milestone 7 Estimated incentive payment: $655,368</td>
<td>Metric 1 [P-3.2]: Train trainees in the medical home model, chronic Care Model and/or disease registry use; have primary care trainees participate in medical homes by managing panels Baseline: None (new program) Goal: 5 new residents Data Source: Curriculum, rotation hours, and/or patient panels assigned to resident/trainee Milestone 10 Estimated incentive payment: $656,316</td>
<td></td>
</tr>
</tbody>
</table>

| Year 2 Estimated Milestone Bundle Amount: $1,676,230 | Year 3 Estimated Milestone Bundle Amount: $1,740,675 | Year 4 Estimated Milestone Bundle Amount: $1,966,104 | Year 5 Estimated Milestone Bundle Amount: $1,968,948 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $7,351,957
Project Option 1.2.2- 1.2 Increase training of primary care workforce: Training of Community Health Workers (CHWs)

Unique RHP Project ID: 111810101.1.3
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider: UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s): University of Texas School of Public Health will partner with Gateway to Care, Harris Health System, and UT Physicians to increase the number of certified CHWs in the region (currently approximately 500) and respond to specific continuing education needs as identified by providers and CHWs. In addition, providers and clinic staff will be trained on how to integrate CHWs as members of the health care team.

Need for the project: One of our identified community needs is that there is insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities. CHWs are public health professionals who use their unique understanding of the experiences, language and/or culture of the population they serve to promote health, hence they have proven to be an important link between healthcare providers, researchers and disadvantaged communities.

Target Population: This program targets, primarily, the adult Hispanic population (18 years and above) in our 4 service areas, which number approximately 552,660.

Category 1 or 2 expected patient benefits: We estimate that these CHWs will have made at least 46,000 patient contacts by the end of DY5 and that at the very least, that greater than 40% of these will be Medicaid, or Medicaid eligible, patients. These contacts will help patients participate more fully in their health care, thereby achieving improved health benefits.

Category 3 outcomes:
IT-11.5 (IT-2.10): Our goal is to reduce by 3% in DY4 and 5% in DY5, the percentage of all discharges with a principal diagnosis of flu or pneumonia among Hispanics aged 18 years and older who are patients of UT Physicians.
Project Option 1.2.2 – Increase Training of Primary Care Workforce: Training of Community Health Workers (CHWs)

**Unique RHP Project Identification Number:** 111810101.1.3

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Project Description:** 1.2 Increase training of primary care workforce (Option 1.2.2)

This project will aid the reshaping of the health care system in Southeast Texas. The University of Texas School of Public Health (UTSPH) has a rich history of community health worker (CHW) training and is a state recognized training center. The UTSPH will partner with Gateway to Care, Harris Health System, and UT Physicians (UTP) to increase the number of certified CHWs in the region (currently approximately 500) and respond to specific continuing education needs as identified by providers and CHWs. This project will increase the number of certified CHWs in the RHP3 health care system through community outreach, the provision of scholarships and paid internships, and employment opportunities. UTP alone will provide 24 paid internship-to-employment opportunities, as well as additional scholarships, internships, instructor trainings, and CEU trainings needed to keep CHW certifications current. Additionally, providers and clinic staff will be trained in how to integrate CHWs as members of the health care team.

In the UTP service areas alone, there are large populations with economic, cultural, and language barriers to receiving health care. UTP has defined the service area for its clinics to include the census tracts within a seven-mile radius of each clinic. The Bayshore Clinic is in the southeast area of Houston and includes parts of Pasadena, South Houston, and areas immediate south of the ship channel. The service area of this clinic has a population of 431,199, with 36.5% living at/below the federal poverty level (FPL). The population is 49.2% Hispanic and of those, 51.1% are not proficient in English. The Bellaire Clinic, with a population of 472,698, is on the west side of Houston and also has a large minority population, with 24.1% Black/African American and 46% Hispanic, and 52.2% live at/below the FPL. Of the Spanish-speaking population in the Bellaire Clinic service area, 62.8% are not proficient in English. The Cinco Ranch (population 287,744) and Sienna Village (population 231,535) clinics serve populations reaching into Ft. Bend County that closely mirror the overall county demographics (23.7% Hispanic), with the exception of Sienna Village Clinic, which has a large Black/African American population of 33.5%. There are 20.8% of the Cinco Ranch Clinic population and 26.2% of the Sienna Village Clinic population living at/below the FPL. These two clinics also serve rural populations. Since the Hispanic population would especially benefit from the involvement of CHWs as a part of their health care team, and the large population of Hispanics living within the UTP service areas (approximately 552,660) and the rest of Harris County, this will be our target population. Furthermore, based upon the demographics of UTPs service areas, we expect that there is a greater rate of Medicaid/Medicaid-eligible clients to be served. However, using the overall Harris County rate (14.5%) of Medicaid clients, there would be at least an estimated 1,423,176 Medicaid clients living within the service areas of the UT Physician Clinics. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011.)
Table 1: 2010 Poverty and Median Income Estimates - Counties. The Medicaid rate is from the U.S. Census Bureau and the Centers for Disease Control and Prevention, State and County by Demographic and Income Characteristics. SAHIE, 2009.)

**Goal and Relationship to Regional Goals:**

**Project Goal:**
To increase availability and utilization of certified CHWs trained in organized care delivery models, with an emphasis on team-based practice, quality and cost control, that will serve as members of healthcare delivery teams.

This project addresses the following regional goal:

CHWs will be invaluable in helping the region achieve its goal to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system".

**Challenges:**

Need: 1) Lack of access to culturally appropriate care. 2) Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs.

Implementation: 1) Willingness of other providers/clinicians to incorporate CHWs in their care team. 2) Retention of trained CHWs.

CHWs have been proven to be effective in serving as linkages between patients and the health system, helping patients to navigate the daunting challenges posed by the fragmented nature of health care delivery on the US. Most CHWs come from the local population, are in touch with the community, and are better able to attend to the needs of patients by helping the system to deliver culturally sensitive care and by facilitating their access to health education and support, thereby providing an important and cost effective service to health care teams and to patients. Providers/clinicians will be trained on the value that CHWs bring to the health care team and in how to incorporate them into the practice. The inclusion of CHWs into care teams in their community and competitive compensation will aid in the retention of trained CHWs.

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

Several CHWs will have been trained for practice in the region, and more practices will have CHWs employed in team-based management models. Since CHWs are able to provide patients with culturally appropriate assistance, we would expect better adherence to a regular schedule of primary care and chronic disease treatment plans, thereby producing better health outcomes and reduced need for acute care services. Since 18.7% of the Harris County population is living in poverty (27.1% of children) and 66% of the population are minorities, with 41% being Hispanic, culturally appropriate assistance in navigating the healthcare system and treatment plans will be very important. The inclusion of CHWs into the community clinics and the safety net hospitals in Harris County has the potential to reach large populations of Medicaid and Medicaid-eligible clients. One of the specific improvements we expect to see is higher rates of vaccinations, so we will be measuring a reduction in admissions for influenza and pneumonia for Hispanic patients.

This project will provide scholarships and paid internships for a minimum of 24 CHWs, who will then be placed into full-time positions within the performing provider’s facilities.
estimate that these CHWs will have made at least 46,000 patient contacts by the end of DY5 and that at the very least, that greater than 40% of these will be Medicaid, or Medicaid eligible, patients.

**Starting Point/Baseline:**
In 2012, the UTSPH trained 25 Community Health Workers, which is the baseline for this project. Targets are set based on the project capacity expansion planned through this project.

**Rationale:**

CHWs are members of a team of public health professionals who use their unique understanding of the experiences, language and/or culture of the populations they serve to promote health. CHWs have proven to be an important link between healthcare providers, researchers and disadvantaged communities.

As leaders, CHWs bridge the gap between communities and the public health system – they are resource persons who act as liaisons between residents and health and human services. In the United States, CHWs have been a part of the health care delivery system since the 1960s. Their role has evolved over time and varies according to their work setting, which ranges from outreach workers in the community to clinic staff. CHWs have a broad skill set, including communication, leadership, advocacy, and both general and disease or condition-specific health knowledge. Duties performed by CHWs range from counseling and health education to basic clinical tasks (HRSA, 2007). Regardless of their work environment, CHWs are trusted members of the community in which they work and typically reflect the demographic characteristics of the area. Their knowledge of local culture and customs allows them to effectively deliver direct health messages to community members, provide services, connect them to local health and social services, and advocate on their behalf. Nationally and internationally, CHWs are viewed as part of the solution for achieving improved health status in rural and disenfranchised communities.

For many years CHWs have provided an array of health care services in different settings. Recently their role has been elevated, nationally and internationally, as opportunities for integrating CHWs into the health care delivery system are discussed. In 2009, the US Department of Labor recommended the creation of a Standard Occupational Classification for CHWs. This act opened the door for additional integration into the US health system. The 2010 Patient Protection and Affordable Care Act (health reform law) identified community health workers as having major roles in achieving the goals of health care reform. At the International level, the United Nations Millennium Development Goals (MDGs) acknowledge the importance of human capital. In an effort to progress toward meeting health-related MDGs, the World Health Organization recommends CHWs as a part of the health service workforce (Achieving the health-related MDGs. It takes a workforce! 2010).

This project aims to improve health outcomes, return-on-investment, and increased patient satisfaction when CHWs are integrated into the health care team in clinics southeast Texas.

**Project Components:**

Through the training of Community Health Workers (CHWs) project, we propose to meet all required project components listed below.

a) Recruit and train more community health workers/promotoras by providing scholarships and other incentives,
b) Train providers and clinic staff on how to integrate CHWs as members of the health care team,
c) Provide clinical rotations/internships for CHWs with UT Physician healthcare teams and other healthcare provider teams throughout the region, and
d) Provide job placement opportunities for graduating certified CHWs.

**Milestones and Metrics:**

For the Training of Community Health Workers (CHWs) Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

**Process Milestones and Metrics:**

**Milestone 1 [P-1]:** Conduct a primary care gap analysis to determine workforce needs.
Metric 1 [P-1.1]: Gap assessment of workforce shortages to be filled by Community Health Workers

**Milestone 2 [P-X1]:** Implement scholarship program for community health worker training
Metric 1 [P-X1.1]: Grant tuition assistance for new community health worker trainees admitted into the program

**Milestone 3 [P-X2]:** Implement a paid internship program for community health worker trainees
Metric 1 [P-X2.1]: Provide financial support to community health worker trainees rotating at the Performing Provider’s facilities.

**Milestone 4 [P-2]:** Expand primary care training for community health workers
Metric 1 [P-2.1]: Expand other primary care staff (community health workers) training programs (increased applications and agreements to expand training programs)

**Milestone 5 [P-X3]:** Expand primary care training for community health workers
Metric 1 [P-X3.1]: Hire additional precepting CHW mentors/trainers

**Milestone 6 [P-X3]:** Training for faculty/staff
Metric 1 [P-X3.1]: Training for primary care faculty/staff

**Milestone 7 [P-X4]:** Community or population outreach and marketing
Metric 1 [P-X4.1]: Community or population outreach and marketing

**Milestone 8 [P-3]:** Expand positive primary care exposure for Community Health Worker trainees
Metric 1 [P-3.1]: Develop mentoring program with CHW training faculty-mentors and new trainees

**Milestone 11 [P-X3]:** Expand primary care training for community health workers
Metric 1 [P-X3.2]: Conduct continuing education training in 2 additional primary care topics for CHW recertification

**Milestone 12 [P-X3]:** Expand primary care training for community health workers
Metric 1 [P-X3.3]: Conduct training for certification of CHW instructors

**Milestone 15 [P-X3]:** Expand primary care training for community health workers
Metric 1 [P-X3.2]: Conduct continuing education training in 2 additional primary care topics for CHW recertification

**Milestone 16 [P-X3]:** Expand primary care training for community health workers
Metric 1 [P-X3.3]: Conduct training for certification of CHW instructors

**Improvement Milestones and Metrics:**

**Milestone 9 [I-11]:** Increase primary care training for community health workers
Metric 1 [I-11.1]: Increase the number of CHW trainees, as measured by percent change of class size over baseline (number trainees enrolled in CHW training program)

Milestone 10 [I-11]: Increase primary care training rotations/internships for community health workers

Metric 1 [I-11.2]: Increase the number or primary care CHW trainees rotating at the Performing Provider’s facilities

Milestone 13 [I-11]: Increase primary care training for community health workers

Metric 1 [I-11.1]: Increase the number of CHW trainees, as measured by percent change of class size over baseline (number trainees enrolled in CHW training program)

Milestone 14 [I-11]: Increase primary care training rotations/internships for community health workers

Metric 1 [I-11.2]: Increase the number or primary care CHW trainees rotating at the Performing Provider’s facilities

Unique community need identification numbers:

This project addresses community needs CN.20 (Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs) and CN.22 (Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities).

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

This initiative is an expansion of an existing training program. This initiative proposes increasing the number of CHWs trained and placing more CHWs within health care teams in the area. However, there is a new element being added, which is the training of providers in how to integrate CHWs as members of the health care team.

Related Category 3 Outcome Measure(s):

OD-11 Addressing Health Disparities in Minority Populations

- IT-11.5 (IT-2.10) Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure (Standalone measure) (IT-2.10 Flu and pneumonia Admission Rate)
  
  For the Hispanic population:
  
  Numerator: All discharges of age 18 years and older with a principal diagnosis code of flu or pneumonia.
  
  Denominator: Population in Metro Area or county, age 18 years and older.

Relationship to other Projects:

1.1 (C3) - The training of CHWs will increase the availability of support staff for the expansion of primary care capacity.

1.3 (C12) - The disease management registry will help identify patients that need active follow-up, for which CHWs will be uniquely qualified for outreach to non-compliant patients, facilitating their return to appropriate care.
1.7 (A1) - The telemedicine technology will also be available for CHWs in their outreach activities and in facilitating patients’ interaction with their healthcare team, particularly for those patients with distance/transportation barriers.

2.1 (C1-2) - The increased training of CHWs competent to work with the 'new primary care' team-based model of care will be an important component of transitioning patients into medical homes.

2.2 (C5-9,CL3) - Part of the initiatives in the redesigning of chronic care delivery systems is to make better use of non-physician members of the team, such as the CHWs able to facilitate culturally-appropriate communication, education, and navigation, which are important components of the chronic care model.

2.11 (C10) - Trained CHWs able to facilitate culturally-appropriate communication, education, and navigation will be essential to the care team's medication therapy management for minimizing medication errors.

Relationship to Other Performing Providers’ Projects in the RHP:

As the regional healthcare platform aggressively grows, so will the need of workforce expansion to accommodate the needs in order to achieve outcome measures. Workforce expansions range from physician to extender workforce needs and are reflected in the Region 3 Initiative grid in the addendum.

Plan for Learning Collaborative:

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

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTH used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criterion, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. 4. Cost
**Avoidance** (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects. This project’s score for this criterion: 2

5. **Partnership/Collaboration** (Weight = 10%): *This was not rated*, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. **Sustainability** (Weight = 15%): *This was also not rated*, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
### Training of Community Health Workers (CHWs)

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>IT-11.5 (IT-2.10)</th>
<th>Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure (Standalone measure) (IT-2.10 Flu and pneumonia Admission Rate)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-1]: Conduct a primary care gap analysis to determine workforce needs.</td>
<td><strong>Milestone 5</strong> [P-X3]: Expand primary care training for community health workers</td>
<td><strong>Milestone 9</strong> [I-11]: Increase primary care training for community health workers</td>
<td><strong>Milestone 13</strong> [I-11]: Increase primary care training for community health workers</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-1.1]: Gap assessment of workforce shortages to be filled by Community Health Workers Goal: Submission of completed assessment Data Source: Assessment report</td>
<td><strong>Metric 1</strong> [P-X3.1]: Hire additional precepting CHW mentors/trainers Goal: 2 Data Source: HR documents, faculty lists, or other documentation</td>
<td><strong>Metric 1</strong> [I-11.1]: Increase the number of CHW trainees, as measured by percent change of class size over baseline (number trainees enrolled in CHW training program) Baseline: 25 enrollees total for 2012 Goal: 40% increase in class size for the year = 10 additional enrollees Data Source: Training program documentation</td>
<td><strong>Metric 1</strong> [I-11.1]: Increase the number of CHW trainees, as measured by percent change of class size over baseline (number trainees enrolled in CHW training program) Baseline: 25 enrollees total for 2012 Goal: 56% increase in class size for the year = 14 additional enrollees Data Source: Training program documentation</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-X1] Implement scholarship program for community health worker training</td>
<td><strong>Milestone 6</strong> [P-X3] Training for faculty/staff</td>
<td><strong>Milestone 10</strong> [I-11]: Increase primary care training rotations/internships for community health workers</td>
<td><strong>Milestone 14</strong> [I-11]: Increase primary care training rotations/internships for community health workers</td>
</tr>
<tr>
<td><strong>Metric 1</strong>[P-X1.1]: Grant tuition assistance for new community health worker trainees admitted into the training program. Goal: Establish a tuition assistance program for students working as interns for UTP. Data Source: Program documentation</td>
<td><strong>Metric 1</strong> [P-X3.1] Training for primary care faculty/staff Goal: Train at least 2 primary care faculty/staff per clinic in how to integrate CHWs as members of the health care team. Data Source: Training records</td>
<td><strong>Metric 1</strong> [I-11.2]: Increase the number of primary care CHW trainees rotating at the Performing Provider’s facilities Baseline: 0 Goal: 10 CHW internships Data Source: Training program documentation</td>
<td><strong>Metric 1</strong> [I-11.2]: Increase the number of primary care CHW trainees rotating at the Performing Provider’s facilities Baseline: 0 Goal: 14 CHW internships Data Source: Training program documentation</td>
</tr>
<tr>
<td><strong>Milestone 3</strong> [P-X2] Implement a paid internship program for community</td>
<td><strong>Milestone 7</strong> [P-X4] Community or population outreach and marketing</td>
<td><strong>Milestone 10 Estimated incentive</strong></td>
<td><strong>Milestone 13 Estimated incentive</strong> payment: $ 747,663</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-X4.1] Community or population outreach and marketing Goal: Conduct community or</td>
<td><strong>Milestone 10</strong> Estimated incentive payment: $ 758,355</td>
<td><strong>Metric 1</strong> [I-11.1]: Increase primary care training for community health workers</td>
<td><strong>Metric 1</strong> [I-11.1]: Increase primary care training for community health workers</td>
</tr>
<tr>
<td><strong>Milestone 4</strong> [I-11]: Increase primary care training rotations/internships for community health workers</td>
<td><strong>Milestone 13</strong> Estimated incentive payment: $ 758,355</td>
<td><strong>Milestone 14</strong> Estimated incentive payment: $ 747,663</td>
<td><strong>Milestone 14</strong> Estimated incentive payment: $ 747,663</td>
</tr>
</tbody>
</table>

**Regional Healthcare Partnership Plan**

**Region 3**

**859**
**TRAINING OF COMMUNITY HEALTH WORKERS (CHWs)**

<table>
<thead>
<tr>
<th><strong>111810101.1.3</strong></th>
<th><strong>1.2.2</strong></th>
<th><strong>TR</strong></th>
<th><strong>COMMUNITY</strong></th>
<th><strong>HEALTH</strong></th>
<th><strong>WORKERS (CHWs)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td><strong>111810101.3.7</strong></td>
<td><strong>IT-11.5 (IT-2.10)</strong></td>
<td><strong>Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure (Standalone measure) (IT-2.10 Flu and pneumonia Admission Rate)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</th>
<th><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</th>
<th><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</th>
<th><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>health worker trainees</strong></td>
<td><strong>population outreach and marketing for the CHW training program</strong></td>
<td><strong>payment: $ 788,354</strong></td>
<td><strong>Milestone 15 [P-X3]: Expand primary care training for community health workers</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [P-X2.1]: Provide financial support to community health worker trainees rotating at the Performing Provider’s facilities.</strong></td>
<td><strong>Data Source: Program records including student recruitment sessions at local events, advertisements, etc.</strong></td>
<td><strong>Metric 1 [P-X3.2]: Conduct continuing education training in 2 additional primary care topics for CHW recertification</strong></td>
<td><strong>Goal: 2 CEU courses</strong></td>
</tr>
<tr>
<td><strong>Goal: UTP to implement a paid internship program for CHW trainees</strong></td>
<td><strong>Milestone 7 Estimated incentive payment $ 691,734</strong></td>
<td><strong>Data Source: Training documents,</strong></td>
<td><strong>Data Source: Training documents,</strong></td>
</tr>
<tr>
<td><strong>Data Source: Program documentation</strong></td>
<td><strong>Milestone 8 [P-3] Expand positive primary care exposure for Community Health Worker trainees</strong></td>
<td><strong>Milestone 11 Estimated incentive payment: $ 788,354</strong></td>
<td><strong>Milestone 15 Estimated incentive payment: $ 747,662</strong></td>
</tr>
<tr>
<td><strong>Milestone 3 Estimated incentive payment: $ 646,546</strong></td>
<td><strong>Metric 1 [P-3.1] Develop mentoring program with CHW training faculty-mentors and new trainees</strong></td>
<td><strong>Metric 1 [P-X3.3]: Conduct training for certification of CHW instructors</strong></td>
<td><strong>Goal: 1 instructor training session</strong></td>
</tr>
<tr>
<td><strong>Milestoneworld 8 [P-3] Expand positive primary care exposure for Community Health Worker trainees</strong></td>
<td><strong>Goal: Documentation of program Data Source: Mentoring program curriculum</strong></td>
<td><strong>Data Source: Training documents,</strong></td>
<td><strong>Data Source: Training documents,</strong></td>
</tr>
<tr>
<td><strong>Data Source: Training program documentation</strong></td>
<td><strong>Milestone 8 Estimated incentive payment $ 691,734</strong></td>
<td><strong>Milestone 12 Estimated incentive payment: $ 788,354</strong></td>
<td><strong>Milestone 16 Estimated incentive payment: $ 747,662</strong></td>
</tr>
<tr>
<td><strong>Milestone 4 [P-2]: Expand primary care training for community health workers</strong></td>
<td><strong>Metric 1 [P-2.1]: Expand other primary care staff (community health workers) training programs (increased applications and agreements to expand training programs)</strong></td>
<td><strong>Milestone 12 [P-X3]: Expand primary care training for community health workers</strong></td>
<td><strong>Metric 1 [P-X3.3]: Conduct training for certification of CHW instructors</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [P-2.1]: Expand other primary care staff (community health workers) training programs (increased applications and agreements to expand training programs)</strong></td>
<td><strong>Goal: Documentation of applications and agreements to expand training programs</strong></td>
<td><strong>Goal: 1 instructor training session</strong></td>
<td><strong>Goal: 1 instructor training session</strong></td>
</tr>
<tr>
<td><strong>Data Source: Training program documentation</strong></td>
<td><strong>Data Source: Training program documentation</strong></td>
<td><strong>Data Source: Training documents,</strong></td>
<td><strong>Data Source: Training documents,</strong></td>
</tr>
<tr>
<td><strong>Milestone 4 Estimated incentive payment: $ 646,545</strong></td>
<td><strong>Milestone 8 Estimated incentive payment: $ 691,734</strong></td>
<td><strong>Milestone 12 Estimated incentive payment: $ 788,354</strong></td>
<td><strong>Milestone 16 Estimated incentive payment: $ 747,662</strong></td>
</tr>
</tbody>
</table>

<p>| <strong>Year 2 Estimated Milestone Bundle Amount: $2,586,183</strong> | <strong>Year 3 Estimated Milestone Bundle Amount: $2,766,938</strong> | <strong>Year 4 Estimated Milestone Bundle Amount: $3,033,417</strong> | <strong>Year 5 Estimated Milestone Bundle Amount: $2,990,650</strong> |</p>
<table>
<thead>
<tr>
<th>111810101.1.3</th>
<th>1.2.2</th>
<th>TRAINING OF COMMUNITY HEALTH WORKERS (CHWs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTHealth, UTPhysicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>111810101.3.7</td>
<td>IT-11.5 (IT-2.10)</td>
<td>Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure (Standalone measure) (IT-2.10 Flu and pneumonia Admission Rate)</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong></td>
<td><strong>$11,377,188</strong></td>
<td></td>
</tr>
</tbody>
</table>
Project Option 1.3.1- 1.3 Implement a Chronic Disease: UT Physicians Chronic Disease Registry

Unique RHP Project ID: 111810101.1.4
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider: UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s): Data entered into a unique chronic disease registry will be used to pro-actively contact, educate, and track patients by disease status, risk status, self management status, community and family need. Reports drawn from the registry will be used to develop and implement targeted quality improvement plans for diabetes, hypertension, asthma, COPD, and CHF.

Need for the project: Our service population has high rates of chronic disease, and there is lack of care coordination due to insufficient implementation and use of electronic health records. Utilization of registry functionalities will help our care teams to actively manage patients with targeted chronic conditions because the registry will include clinician prompts and reminders, which would aid in the delivery of proactive care.

Target Population: This project targets patients in our service area with diabetes, hypertension, asthma, COPD, or CHF. Patients of lower socioeconimic status (which number approximately 448,583 for the UTP clinics service areas) are known to have worse disease control due to the inability to maintain compliance in the long run, hence this project will be beneficial to the Medicaid population in the UTP clinics service areas.

Category 1 or 2 expected patient benefits:
By the end of DY4, we expect to have over **12,000** people with a chronic disease entered into the registry and by the end of DY5, we expect to have made approximately **40,000** patient contacts resulting from use of the registry that will facilitate the management of the chronic diseases of these patients.

Category 3 outcomes:
IT-1.7: Our goal is to improve, the percentage of UT Physician’s patients (ages 18 to 85 years) with a diagnosis of hypertension, whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year.
Project Option 1.3.1 – Implement a Chronic Disease Management Registry: UT Physicians

Unique RHP Project Identification Number: 111810101.1.4
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 1.3 Implement a Chronic Disease Management Registry (Option 1.3.1)

UT Physicians will implement and use chronic disease management registry functionalities. Data entered into a unique chronic disease registry will be used to pro-actively contact, educate, and track patients by disease status, risk status, self management status, community, and family need. Reports drawn from the registry will be used to develop and implement targeted QI plans for diabetes, hypertension, asthma, COPD, and CHF. Utilization of registry functionalities helps care teams to proactively manage patients with targeted chronic conditions because the disease management registry will include clinician prompts and reminders, which would aid in the delivery of proactive care to patients with chronic diseases. With the high rates of chronic diseases in RHP3 (CN.11), the use of a chronic disease registry will be an important tool in our ability to provide the best quality of care for patients with diabetes, hypertension, asthma, COPD, and CHF. UTP provided 321,716 patient visits during FY 2012. Based upon current data, we have over 12,000 unique patients with a diagnosis of one of the chronic diseases being targeted with the chronic disease registry program. Additionally, we are expecting growth in patient visits by about 42,000 for primary care and 38,000 for specialty care due to expansion in these areas, which means that we will be providing over 400,000 patient visits by the end of DY5 (most of this growth is expected to be among Medicaid/Medicaid-eligible clients). With a patient base this large, a chronic disease registry will be not only key to providing proactive high-quality care, but will also allow us to identify trends to be addressed through interventions and quality improvement processes.

Through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.

Goal and Relationship to Regional Goals:
Project Goal:
To track key patient information, thereby enabling physicians and other members of a patient’s care team to identify and reach out to patients who may have gaps in their care in order to prevent complications, which often lead to more costly care interventions.

This project addresses the following regional goal:
By establishing disease specific registries, providers will have the benefit of a rich information source on the dynamics/progress of patients under their care. This taps into the regional goal that aims to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system."
Challenges:

Need: 1) Lack of care coordination and unnecessary duplication of services due to insufficient implementation and use of electronic health records. 2) High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease. Implementation: 1) Recruitment and training of case managers to run the registries. 2) Capacity to act on data output from registry.

In addition to the high rates of chronic diseases in the population, the failure to make maximum use of the support of clinical information technology has hampered the effective management of such diseases. Information technology, which is part of Wagner's chronic care model, has been shown to contribute positively to the delivery of a proactive care that keeps patients healthy as much as possible and achieve stable states in disease conditions by yielding timely actionable information.

5-Year Expected Outcome for Provider and Patients:

Chronic disease registries will have been created and incorporated into the care models for the targeted diseases for the delivery of proactive and coordinated care for patients with chronic diseases, such as cardiovascular disease/hypertension. We expect that improved care for these patients will result in better outcomes and less need for acute episodic care, thereby lowering ED utilization for patients with cardiovascular disease/hypertension. In addition to benefiting the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base of UTP clinics, the expansion of primary care and specialty care services will be marketed to the additional 1,423,176 Medicaid and Medicaid-eligible residents living within the service areas of the UT Physician Clinics with cardiovascular disease/hypertension. Since we are expecting growth in our clinics by at least 42,000 patient visits by the end of DY5, and we expect the growth to be primarily in the Medicaid/Medicaid eligible patients (raising our percentage of Medicaid patient visits) the use of the disease registry will potentially benefit a rather large number of people.

By the end of DY4, we expect to have over 12,000 people with a chronic disease entered into the registry and by the end of DY5, we expect to have made approximately 40,000 patient contacts resulting from use of the registry.

Starting Point/Baseline:
The implementation of a chronic disease registry is a new project. Consequently, baselines are set at zero. Targets are set based upon the current number of unique patients with a diagnosis of one of the 5 targeted chronic diseases (asthma, diabetes, CHF, COPD, hypertension).

Rationale:

Utilization of registry functionalities helps care teams to actively manage patients with targeted chronic conditions because the disease management registry will include clinician prompts and reminders, which would aid in the delivery of proactive care to patients with chronic diseases. The following statistics on select chronic diseases demonstrate the need for tools and processes that assist in the management of these diseases, such as the chronic disease registry.

Asthma is increasing every year in the US; the proportion of people with asthma in the United States grew by nearly 15% in the last decade. There is significant disparities in asthma prevalence in the US. Adults with an annual household income of $75,000 or less are more likely
to have asthma than adults with higher incomes. (Asthma’s Impact on the Nation: Data from the
CDC National Asthma Control Program. Available at: http://www.cdc.gov/asthma/impacts_nation/AsthmaFactSheet.pdf. Accessed 10/15/12). Hence the Medicaid population has
a higher prevalence of asthma. Asthma costs the US about $3,300 per person with asthma each
year from 2002 to 2007 in medical expenses. Medical expenses associated with asthma increased
from $48.6 billion in 2002 to $50.1 billion in 2007. About 2 in 5 (40%) uninsured people with
asthma could not afford their prescription medicines and about 1 in 9 (11%) insured people with
asthma could not afford their prescription medicines. People with asthma can prevent asthma
attacks if they are taught to use inhaled corticosteroids and other prescribed daily long-term
control medicines correctly and to avoid asthma triggers. In 2008 less than half of people with
asthma reported being taught how to avoid triggers. (CDC 2011: Asthma in the US. Available at:
http://www.cdc.gov/vitalsigns/Asthma/#. Accessed 10/15/12).

Hispanics have a 66% higher risk of being diagnosed with diabetes than non-Hispanic
whites and non-Hispanic blacks have a 77% higher risk. (2011 National Diabetes Fact Sheet,
National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes
estimates11.htm#8 Last reviewed and updated May 23, 2011. Accessed 10-11-12.). About 40%
of Harris County residents are of Hispanic origin (U.S. Census Bureau, 2010 Census Summary
File 1), compared to 16.3% of the US population. Uncontrolled diabetes can result in complications with dire consequences for the patient. For example, the risk of stroke is 2 - 4
times higher among people with diabetes; diabetes is the leading cause of new onset blindness
among adults aged 20 - 74 years in the US; nearly half of all cases of kidney failure can be
attributed to diabetes; and more than half of all cases of nontraumatic lower limb amputations are
because of poorly controlled diabetes. Diabetes also predisposes patients to dental diseases,
pregnancy complications, among other problems. Overall, the risk for death among people with
diabetes is about twice that of people of similar age but without diabetes. Studies in the United
States have shown that improved glycemic control benefits people with either type 1 or type 2
diabetes. In general, every percentage point drop in A1c blood test results (e.g., from 8.0% to
7.0%) can reduce the risk of microvascular complications (eye, kidney, and nerve diseases) by
40%. After adjusting for population age and sex differences, average medical expenditures
among people with diagnosed diabetes were 2.3 times higher than what expenditures would be in
the absence of diabetes. Hence achieving good glycemic control among our diabetic patients will
save the health system a lot of resources.

Around 5.8 million people in the United States have heart failure and about 670,000 people
are diagnosed with it each year. About one in five people who have heart failure die within one
year from diagnosis but early diagnosis and treatment can improve quality of life and life
expectancy for people who have heart failure. Heart failure results in significant costs to the
system; it cost the US nearly $40 billion in 2010 (CDC 2010: heart failure facts. Available at:
10/15/12).

Chronic lower respiratory diseases, primarily COPD, are the third leading cause of death in
the United States, and 5.1% of U.S. adults report a diagnosis of emphysema or chronic bronchitis
(Morbidity and Mortality Weekly Report (MMWR) March 2, 2012 / 61(08);143-146. Available
at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6108a3.htm?s_cid=mm6108a3_w.
Accessed 10/15/12). Excess health-care expenditures are estimated at nearly $6,000 annually for
every COPD patient in the United States (Deaths from Chronic Obstructive Pulmonary Disease -
In 2009-2010, the age-adjusted percentage of US adults with hypertension whose blood pressure was controlled was 53.3%. So nearly half of all hypertensive patients have poor blood pressure control. Yet hypertension is a leading cause of stroke, coronary artery disease, heart attack, and heart and kidney failure in the United States, all of which contribute to the rising costs of health care. Aggressive treatment of hypertension, significantly decreases the risk of coronary artery disease, congestive heart failure, stroke, and resulting disability. For example, a 12-point to 13-point reduction in blood pressure can lower the risk of heart attack by 21%, stroke by 37%, and total cardiovascular deaths by 25% (Rein DB, Constantine RT, Orenstein D, Chen H, Jones P, Brownstein JN, et al. A cost evaluation of the Georgia Stroke and Heart Attack Prevention Program. Prev Chronic Dis [serial online] 2006 Jan [date cited]. Available from: URL: http://www.cdc.gov/pcd/issues/2006/jan/05_0143.htm. Accessed on 10/15/12). Low-income individuals without prescription drug coverage are significantly more likely to skip doses to save money or make their hypertension medication prescriptions last longer. (Rein DB, Constantine RT, Orenstein D, Chen H, Jones P, Brownstein JN, et al. A cost evaluation of the Georgia Stroke and Heart Attack Prevention Program. Prev Chronic Dis [serial online] 2006 Jan [date cited]. Available from: URL: http://www.cdc.gov/pcd/issues/2006/jan/05_0143.htm. Accessed on 10/15/12).

Project Components:
Through the UT Physicians Chronic Disease Registry Program, we propose to meet all required project components listed below.

a) UTP will develop a chronic disease registry to track and monitor patients with diabetes, hypertension, asthma, COPD, and CHF,
b) Test and validate the accuracy of the registry, and
c) Train UTP faculty & staff on how to use the registry to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.
d) UTP’s quality improvement office will use registry reports to develop and implement a targeted QI plan,
e) Conduct quality improvement for the project using methods such as rapid cycle improvement.

Milestones and Metrics:
For the UT Physicians Chronic Disease Registry Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

Milestone 1 [P-3]: Develop cross-functional team to evaluate registry program.
Metric 1 [P-3.1]: Documentation of personnel (clinical, IT, administrative) assigned to evaluate registry program

Milestone 2 [P-10]: Implement cross-functional team to staff registry program.
Metric 1 [P-10.1] Documentation of personnel (clinical, IT, administrative) assigned to staff registry program

Milestone 3 [P-6]: Conduct staff training on populating and using registry functions.
Metric 1 [P-6.1]: Documentation of training programs and list of staff members trained, or other similar documentation

**Milestone 4** [P-1]: Identify one or more target patient populations diagnosed with diabetes, hypertension, asthma, COPD, or CHF.

Metric 1 [P-1.1]: Proportion of patients with hypertension targeted and entered into the registry

**Milestone 5** [P-8]: Create/disseminate protocols for registry-driven reminders and reports for clinicians and providers regarding key health indicator monitoring and management in patients with targeted diseases

Metric 1 [P-8.1]: Submitted protocols for the specified conditions and health indicators

**Milestone 6** [P-14]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

Metric 1 [P-14.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Milestone 7** [P-1]: Identify one or more target patient populations diagnosed with diabetes, hypertension, asthma, COPD, or CHF.

Metric 1 [P-1.1]: Proportion of patients with diabetes, asthma, COPD, or CHF targeted and entered into the registry

**Milestone 8** [P-7]: Develop and implement testing to evaluate the accuracy of the registry and effectiveness in addressing treatment gaps and reducing preventable acute care.

Metric 1 [P-7.1]: Implement and document results of test plan.

**Milestone 9** [P-14]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

Metric 1 [P-14.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Improvement Milestones and Metrics:**

**Milestone 10** [I-16]: Increase the number of patient contacts recorded in the registry relative to baseline rate.

Metric 1 [I-16.1]: Total number of in-person and virtual (including email, phone and web-based) visits, either absolute or divided by denominator.

**Milestone 11** [I-16]: Increase the number of patient contacts recorded in the registry relative to baseline rate and showing an increase over the previous reporting period.

Metric 1 [I-16.1]: Total number of in-person and virtual (including email, phone and web-based) visits, either absolute or divided by denominator.

**Milestone 12** [I-21] Increase the number of clinicians and staff using the registry

Metric 1 [I-21.1] Metric: Number of clinicians and staff using the registry

**Milestone 13** [P-14]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

Metric 1 [P-14.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.
Unique community need identification numbers the project addresses:
This project addresses community needs CN.11 (High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease) and CN.24 (Lack of care coordination and unnecessary duplication of services due to insufficient implementation and use of electronic health records).

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
The Chronic Disease Management Registry project represents a new initiative, since this does not currently exist. This initiative will improve our ability to provide pro-active patient-centered care for those with chronic diseases, track these patients, and ensure adherence to treatment plans.

Related Category 3 Outcome Measure(s):
OD-1 Primary Care and Chronic Disease Management
- IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)12 (Stand-alone measure)
  Improve the number of patients 18 to 85 years of age with a diagnosis of hypertension whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year.

Relationship to other Projects:
1.1 (C3) - Expanded primary care capacity will enable the effective use of the outputs of the disease management registries to bridge gaps for at-risk patients.
1.7 (A1) - Reports from the disease management registry can be transmitted to a specialist at a distant site using telemedicine facilitating quality care.
1.9 (C4) - The disease management registry will serve as a useful resource to every specialty provider involved in managing the enrolled patients.
1.10 (MS1) - The chronic disease registries will make available useful QI data that will be used to populate the QI dashboards under project MS1.
2.1 (C1-2) - The disease management registry will serve as a useful resource to every member of the medical home care team involved in managing the enrolled patients.
2.2 (C5-9,CL3) - The disease management registry (Information Technology support) is a very important component of Wagner's Chronic Care Model being implemented in these projects.
2.11 (C10) - The disease management registries and the medication management project will complement each other to ensure patients with chronic diseases, especially those with multiple chronic conditions, get optimal care with minimal errors and sustained active follow up.
2.12 (A3, CL1, CL2, MS4) - The disease management registry will provide important technological support to the care transitions projects with the aim of tracking patients to ensure adequate, sustained follow up.

Relationship to Other Performing Providers’ Projects in the RHP:
The sheer volume of population as well as the complexity of patient conditions dictates the need of numerous disease registries in our region to properly identify and manage chronic conditions. The concept is utilized consistently throughout our region in order to help achieve
milestones and outcomes specific to patient conditions. All disease registries presented have a similarity in concept but are unique in the sense of condition or patient population focus. The Region 3 initiative grid in the addendum reflects direct relations between all projects.

**Plan for Learning Collaborative:**

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

**Project Valuation:**

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. **Transformational Impact** (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. **Population Served/Project Size** (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.

3. **Aligned with Community Needs** (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. **Cost Avoidance** (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects.

5. **Partnership/Collaboration** (Weight = 10%): This was not rated, because UTHHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. **Sustainability** (Weight = 15%): This was also not rated, because UTHHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar, ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>UT Physicians CHRONIC DISEASE REGISTRY</th>
</tr>
</thead>
<tbody>
<tr>
<td>111810101.3.8</td>
<td>111810101.3.8</td>
<td>UTHealth, UTPhysicians</td>
</tr>
</tbody>
</table>

**Milestone 1 [P-3]:** Develop cross-functional team to evaluate registry program.

**Metric 1 [P-3.1]:** Documentation of personnel (clinical, IT, administrative) assigned to evaluate registry program.

Baseline: None (new program)

Goal: Provide documentation of personnel assigned to evaluation registry program, including a project manager; IT Admin personnel responsible for EMR; Nursing Leaders; Clinician Leaders

Data source: Team roster, roles, and minutes from team meetings

Milestone 1 Estimated incentive payment: $606,636

**Milestone 2 [P-10]:** Implement cross-functional team to staff registry program.

**Metric 1 [P-10.1]:** Documentation of personnel (clinical, IT, administrative) assigned to staff registry program.

Data source: HR records

Milestone 2 Estimated incentive payment: $606,636

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Year 2:**

**Milestone 1 [P-1]:** Identify one or more target patient populations diagnosed with diabetes, hypertension, asthma, COPD, or CHF.

**Metric 1 [P-1.1]:** Proportion of patients with hypertension targeted and entered into the registry.

Baseline: 7001 distinct patients with a diagnosis of hypertension.

Goal: 90% of patients with a hypertension diagnosis will be entered into the registry.

Data source: UT Physicians' records/documentation and registry.

Milestone 4 Estimated incentive payment: $634,239

**Milestone 5 [P-8]:** Create/disseminate protocols for registry-driven reminders and reports for clinicians and providers regarding key health indicator monitoring and management in patients with targeted diseases.

**Metric 1 [P-8.1]:** Submitted protocols for the specified conditions and health indicators.

Baseline: 0 (new program)

Milestone 7 Estimated incentive payment: $533,657

**Year 3:**

**Milestone 1 [P-1]:** Identify one or more target patient populations diagnosed with diabetes, hypertension, asthma, COPD, or CHF.

**Metric 1 [P-1.1]:** Proportion of patients with diabetes, asthma, COPD, or CHF targeted and entered into the registry.

Baseline: 5878 distinct patients with a diagnosis of diabetes, asthma, COPD, or CHF.

Goal: 90% of patients with a diagnosis of diabetes, asthma, COPD, or CHF will be entered into the registry.

Data source: UT Physicians' records/documentation and registry.

Milestone 4 Estimated incentive payment: $634,239

**Milestone 6 [P-7]:** Develop and implement testing to evaluate the accuracy of the registry and effectiveness in addressing treatment gaps and reducing preventable acute care.

**Metric 1 [P-7.1]:** Implement and document results of test plan.

**Year 4:**

**Milestone 11 [I-16]:** Increase the number of patient contacts recorded in the registry relative to baseline rate and showing an increase over the previous reporting period.

**Metric 1 [I-16.1]:** Total number of in-person and virtual (including email, phone and web-based) visits, either absolute or divided by denominator.

Baseline: 0 (new program), but will increase contacts over the previous reporting period (DY4).

Goal: 20,606 contacts (We expect to be able to make 2 contacts with at least 80% of our unique patients entered into the registry, which is a 5% increase over the previous year.)

Data source: Internal clinic records/documentation

Milestone 11 Estimated incentive payment: $710,090

**Year 5:**

**Milestone 12 [I-21] Increase the number of clinicians and staff using the registry.

**Metric 1 [I-21.1]:** Metric: Number of clinicians and staff using the registry.

Goal: 25%

Data Source: Registry report
### Regional Healthcare Partnership Plan

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>UT Physicians Chronic Disease Registry</th>
</tr>
</thead>
<tbody>
<tr>
<td>111810101.3.8</td>
<td>UTHealth, UTPhysicians</td>
</tr>
<tr>
<td>1.3.1</td>
<td>UT Physicians Chronic Disease Registry</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>payment: $606,635</td>
<td>Goal: Protocols disseminated to 100% clinic providers Data source: Protocols Milestone 5 Estimated incentive payment: $634,239</td>
</tr>
<tr>
<td><strong>Milestone 3 [P-6]</strong>: Conduct staff training on populating and using registry functions. Metric 1 [P-6.1]: Documentation of training programs and list of staff members trained, or other similar documentation Baseline: 0 (new program) Goal: 5 nurse case managers to be hired and trained Data source: HR or training program materials Milestone 3 Estimated incentive payment: $606,635</td>
<td><strong>Milestone 6 [P-14]</strong>: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-14.1]: Participate in semiannual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in at least 2 meetings per year Data source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated incentive payment: $634,238</td>
</tr>
<tr>
<td><strong>Milestone 10 [I-16]</strong>: Increase the number of patient contacts recorded</td>
<td><strong>Milestone 10 [I-16]</strong>: Increase the number of patient contacts recorded</td>
</tr>
<tr>
<td>111810101.1.4</td>
<td>1.3.1</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>UTHealth, UTPhysicians</td>
<td>111810101</td>
</tr>
</tbody>
</table>

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

| 111810101.3.8 | IT-1.7 | Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)12 (Stand-alone measure) |

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| in the registry relative to baseline rate.  
  **Metric 1 [I-16.1]:** Total number of in-person and virtual (including email, phone and web-based) visits, either absolute or divided by denominator. Baseline: 0 (new program) Goal: 19,318 patient contacts (we expect to be able to make 2 contacts with at least 75% of our unique patients entered into the registry. Data source: Internal clinic records/documentation  
Milestone 10 Estimated incentive payment: $533,656 |

| Year 2 Estimated Milestone Bundle Amount: $1,819,906 | Year 3 Estimated Milestone Bundle Amount: $1,902,716 | Year 4 Estimated Milestone Bundle Amount: $2,134,627 | Year 5 Estimated Milestone Bundle Amount: $2,130,270 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $7,987,519
Project Option 1.6.2- 1.6 Enhance Urgent Medical Advice: UT Health Nurse-line Medical Triage Call Center

Unique RHP Project ID: 111810101.1.5
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
This project will expand access to medical advice and guidance to the appropriate level of care in order to reduce emergency department use for non-emergent conditions, and it will also increase patient access to health care by implementing a nurse-line medical triage call center that will be staffed 24/7/365.

Need for the project:
Our existing nurse line is partial (only exists in two clinics), not-centralized, not available all day and all week round, and does not have full Spanish options. There is need to make the service more culturally sensitive and accessible by expanding the service in Spanish, having a centralized line, and making it available round-the-clock. This will address the need to provide the right care in the right setting at the right time, and hence reduce primary care related emergency department visits.

Target Population:
All current and prospective clients of UTP. However, patients with chronic diseases, such as chronic obstructive pulmonary diseases, asthma, heart failure, pulmonary edema, Hypertension, Angina, or Diabetes are likely to benefit the most. In FY 2012, UTP provided 321,716 patient visits. With UTPs planned expansion of primary care and specialty care capacity, we expect to provide over 400,000 patients visits by DY5.

Category 1 or 2 expected patient benefits:
This project will provide enhanced urgent medical advice by telephone 24/7/365 for an estimated 140,780 patient encounters by the end of DY5, of which includes a minimum of over 32,300 Medicaid patients. Also, we expect more than 20,000 unique patients will receive valuable health and health system information to help them make better informed choices about their health.
Category 3 outcomes:
IT-9.2 ED appropriate utilization: Reduce Emergency Department visits for Asthma, COPD, CHF, Diabetes, Hypertension
Project Option 1.6.2 – Enhance Urgent Medical Advice: UT Health Nurse-line Medical Triage Call Center

**Unique RHP Project Identification Number:** 111810101.1.5  
**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Project Description:** 1.6 Enhance Urgent Medical Advice (Option 1.6.2)

UT Physicians (UTP) will expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care by implementing a nurse-line medical triage call center that will be staffed 24/7/365. The nurses receiving the calls will have access to the UT Physicians Schedule Now system to find an appropriate physician to see the patient in a primary care setting for non-emergent conditions. Furthermore, for patients needing urgent medical guidance who are already patients of UT Physicians, the nurses will have access to their EMR through Allscripts. Also, the nurse triage line will be enhanced by the addition of an on-call physician available to assist nurses in providing urgent medical advice for more complex, or sensitive, patient needs that may outreach the licensure of the nurse. Patients calling the nurse triage line will be assured of receiving appropriate medical advise regardless of the time of day, or day of the year. Patients calling the nurse line will also have access to community health workers able to provide navigational and health education services to callers when needed. The nurse line will always be staffed by bi-lingual nurses, providing services in Spanish and English. Other languages will also be accommodated through a translation service that is available to the nurse at all times. This nurse triage line will provide exceptionally enhanced capacity for substantially meaningful urgent medical advice. Also, UT Health will be participating in the local public hospital HIE with Memorial Hermann to provide patients with the ability to participate in an HIE for enhanced patient care and provider communication as well as enhanced PI and QI initiatives. This will further enhance the triage nurse's ability to access pertinent information when advising callers.

The UT Physicians practice includes over 900 physicians located in the Texas Medical Center and in 4 out-lying clinics, which provides patients with greater access to care. In FY 2012, UTP provided 321,716 patient visits. With UTPs planned expansion of primary care and specialty care capacity, we expect to provide over 400,000 patients visits by DY5. The nurse triage line will be an important tool in the provision of appropriate care to clients and in avoiding unnecessary Emergency Department use.

Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.
Goal and Relationship to Regional Goals:
Project Goal:
To provide urgent medical advice so that patients who need it can access it telephonically, and an appropriate appointment can be scheduled so that access to urgent medical care is increased and avoidable utilization of urgent care and the ED can be reduced.

This project addresses the following regional goal:
This project relates to the regional goal that aims to "develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction", since it is going to expand the existing nurse line to better meet the needs of patients.

Challenges:
Need: 1) High rates of inappropriate emergency department utilization. 2) High rates of preventable hospital admissions.
Implementation: 1) Low health literacy levels and low economic resources of the population can influence the ability to effectively utilize the nurse line. 2) Marketing.

By providing readily available triage services patients can conveniently get guidance and advice on non-urgent medical issues and be able to get an appointment set up with a primary care physician when necessary. This will keep people away from the ED. This program will be aggressively advertised to the target population thereby getting them informed about the availability of this free service and increasing its uptake.

5-Year Expected Outcome for Provider and Patients:
We would have a fully functional nurse line to handle calls 24/7/365. There will be marketing and education of patients (in English and in Spanish) on the availability of the service and how to use it. We expect to record increased uptake of the triage services which would decrease ED visits for ambulatory care sensitive conditions. In addition to benefiting the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base of UTP clinics, the expansion of services will be marketed to the additional 1,423,176 Medicaid and Medicaid-eligible residents living within the service areas of the UT Physician Clinics. Since 18.7% of the Harris County population is living in poverty (27.1% of children) and 66% of the population are minorities, with 41% being Hispanic, culturally appropriate assistance in accessing appropriate care will be important in avoiding hospitalizations for ambulatory care sensitive conditions. This project will provide enhanced urgent medical advice by telephone all day and night all year round for an estimated 140,780 patient encounters by the end of DY5. Using our current overall Medicaid base of 23%, this would amount to the provision of urgent medical advice for over 32,300 Medicaid patients. This is a very conservative estimate, because we expect this
rate to increase sharply due to our other DSRIP projects that target Medicaid and Medicaid-eligible populations. Furthermore, due to the ease of use of a nurse advice line and the enhanced language capabilities, this will be an attractive alternative for low-income populations. Finally, because there will also be bilingual patient-focused educational newsletters with proactive health information and reminders that will be distributed based on feedback from the nurse line, we expect more than **20,000 unique patients** will receive valuable health and health system information to help them make better informed choices about their health.

**Starting Point/Baseline:**
UTP currently has two pediatric nurses that triage calls. They only work during clinic business hours. Baseline report for calls triaged showed for the year 2012 there were 20,390 received calls. Of those calls, 62% or 12,573 patients were given an appointment.

**Rationale:**
This project will expand the existing nurse line to become available all day and all week round, in order to be there when needed by patients. It will also be made more culturally sensitive by expanding to offer the service in Spanish and it will be marketed widely to inform the target population of its availability. With the provision of the triage service from nurses who have access to their records at the time of call, patients will be able to receive the right care at the right time, thereby preventing inappropriate use of the ED and quickening the process of getting appointment for urgent primary care needs. This project will address the need to provide the right care in the right setting at the right time, and the need to reduce primary care related emergency department visits.

**Project Components:**
Through the UT Health Nurse-line Medical Triage Call Center Program, we propose to meet all required project components listed below.

- **a)** UTP will develop a 24/7/365 call center staffed by registered nurses that provide timely triage for patients seeking urgent healthcare guidance. Those than can be addressed through primary care services will be either given appointments with an appropriate provider in a timely manner (even same day appointments), or be directed to an alternate primary care site.
- **b)** The UTP nurse triage line will be available in both English and Spanish.
- **c)** Marketing and educational material on use of the nurse triage line will also be in both English and Spanish.
- **d)** UTP Nurses on the triage line will have access to the appointment scheduling system and to patient records.
- **e)** Communication processes will be developed between UTP Nurses and other primary care providers, urgent care providers, and Emergency Departments to improve care transitions for patients.
f) UTP will conduct surveys of patients using the nurse advice line to ensure patient satisfaction with the services received.

g) The UTP quality improvement office will conduct QI for the project using methods such as rapid cycle improvement.

**Milestones and Metrics:**

For the UT Health Nurse-line Medical Triage Call Center Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

**Process Milestones and Metrics:**

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Process/Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 1 [P-X1]:</td>
<td>Complete a planning process/submit a plan in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign</td>
</tr>
<tr>
<td>Metric 1 [P-X1.1.]:</td>
<td>Draft a plan of how the nurse line will operate and protocols to guide nurse triage</td>
</tr>
<tr>
<td>Milestone 2 [P-X2]:</td>
<td>Establish a baseline, in order to measure improvement over self</td>
</tr>
<tr>
<td>Metric 1 [P-X2.1.]:</td>
<td>Assess and document the capacity and usage data for current nurse line.</td>
</tr>
<tr>
<td>Milestone 3 [P-3]:</td>
<td>Train nurses on clinical protocols</td>
</tr>
<tr>
<td>Metric 1 [P-3.1.]:</td>
<td>Number of nurses trained</td>
</tr>
<tr>
<td>Milestone 4 [P-4.]:</td>
<td>Expand nurse advice line based on baseline data to increase access to patients based on need within the RHP.</td>
</tr>
<tr>
<td>Metric 1 [P-4.1.]:</td>
<td>Number of nurses staffing advice line per shift and number of patient calls per shift</td>
</tr>
<tr>
<td>Milestone 5 [P-5.]:</td>
<td>Establish a multilingual nurse advice line</td>
</tr>
<tr>
<td>Metric 1 [P-5.1.]:</td>
<td>Number of bi-lingual nurses staffing advice line per shift</td>
</tr>
<tr>
<td>Milestone 6 [P-6.]:</td>
<td>Inform and educate patients on the nurse advice line</td>
</tr>
<tr>
<td>Metric 1 [P-6.1.]:</td>
<td>Number of targeted patients informed/educated</td>
</tr>
<tr>
<td>Milestone 7 [P-7.]:</td>
<td>Develop/distribute a bilingual (English and Spanish) patient-focused educational newsletter with proactive health information and reminders based on nurse advice line data/generat report identifying common areas addressed by the nurse advice line.</td>
</tr>
<tr>
<td>Metric 1 [P-7.1.]:</td>
<td>Newsletter distribution</td>
</tr>
</tbody>
</table>

**Improvement Milestones and Metrics:**

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Improvement/Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 9 [I-13.]:</td>
<td>Increase in the number of patients that accessed the nurse advice line over baseline</td>
</tr>
<tr>
<td>Metric 1 [I-13.1.]:</td>
<td>Utilization of nurse advice line</td>
</tr>
<tr>
<td>Milestone 10 [I-13.]:</td>
<td>Increase in the number of patients that accessed the nurse advice line over previous year</td>
</tr>
<tr>
<td>Metric 1 [I-13.1.]:</td>
<td>Utilization of nurse advice line</td>
</tr>
<tr>
<td>Milestone 11 [I-14.]:</td>
<td>Increase patients in defined population who utilized the nurse advice line and were given an urgent medical appointment via the nurse advice and appointment</td>
</tr>
</tbody>
</table>
line when needed

Metric 1 [I-14.1.]: Number of urgent medical appointments scheduled via the nurse advice line

Unique community need identification numbers the project addresses:

This project addresses community needs CN.8 (High rates of inappropriate emergency department utilization) and CN.10 (High rates of preventable hospital admissions).

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

The Nurse-line Medical Triage Call Center project is an expansion of what is mainly an appointment line at this time. UT Physicians currently has a line that patients, or would-be patients can call to be matched with a physician, but it does not operate except during business hours and it does not routinely provide consultation with a nurse for urgent needs. This project proposes to operate a medical triage call center, staffed 24/7/365 by nurses who will have access to patient records and provide guidance to patients regarding next steps that include arranging for same-day appointments in a primary care setting where the need is more urgent.

Related Category 3 Outcome Measure(s):

OD-9 Right Care, Right Setting
- IT-9.2 ED appropriate utilization (Stand-alone measure)
Reduce Emergency Department visits for Asthma, COPD, CHF, Diabetes, Hypertension

Relationship to other Projects:

1.10 (MS1) - The systems engineering and dashboard project will provide a system for continuous quality improvement in the service provided by the nurse triage line.
2.1 (C1-2) - The medical home project and the nurse line will complement each other to ensure that patients get the right care at the right time.
2.9 (A4) - The nurse line will complement the care navigation program, as a 24/7 point of contact, further reducing the risk of avoidable utilization of the ED.
2.11 (C10) - The medication management program with its technological support will provide the nurses with useful information on patients to inform more efficient triaging.
2.12 (A3, CL1, CL2, MS4) - The nurse triage line will complement the care transition projects, as a 24/7 point of contact to ensure that patients get the right care at the right time.

Relationship to Other Performing Providers’ Projects in the RHP:

The triage and intake process of patient encounters is the front door to healthcare and an important factor of the success of healthcare transformation. The nurse triage/call center concept is unique in the regional sense of the RHP plan and focuses to outcome measures of ambulatory care sensitive condition readmission rates. The initiative grid attached in the addendum will show similarities with other projects suggested for this region.
Plan for Learning Collaborative:

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

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects.

5. Partnership/Collaboration (Weight = 10%): This was not rated, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): This was also not rated, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-X1]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign</td>
<td><strong>Milestone 4</strong> [P-4]: Expand nurse advice line by 600% based on baseline data to increase access to patients based on need within the RHP. <strong>Metric 1</strong> [P-4.1]: Number of nurses staffing advice line per shift and number of patient calls per shift Baseline: Currently have 2 pediatric nurses triaging calls during clinic business hours. Total calls received 20,390 Goal: Add 3 lines, extend service to 24 hours/day, 365 days/year, and add 12 nurses to staff the triage line. Data Source: Documentation of nurse advice line staffing levels.</td>
<td><strong>Milestone 7</strong> [P-7]: Develop/distribute a bilingual (English and Spanish) patient-focused educational newsletter with proactive health information and reminders based on nurse advice line data/generated report identifying common areas addressed by the nurse advice line. <strong>Metric 1</strong> [P-7.1]: Newsletter distribution Goal: 20,000 unique patients Data Source: Distributed newsletters</td>
<td><strong>Milestone 10</strong> [I-13.1]: Increase in the number of patients that accessed the nurse advice line <strong>Metric 1</strong> [I-13.1.1]: Utilization of nurse advice line Goal: Increase by 20,000 answered calls over previous year, the number of calls answered, to a total of 80,390 calls Data Source: Call Center phone and encounter records and appointment scheduling software records</td>
</tr>
<tr>
<td>Milestone 1 Estimated incentive payment: $ 1,356,948</td>
<td>Milestone 4 Estimated incentive payment: $ 1,480,456</td>
<td>Milestone 7 Estimated incentive payment: $1,591,608</td>
<td>Milestone 10 Estimated incentive payment: $ 2,328,819</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-X2]: Establish a baseline, in order to measure improvement over self <strong>Metric 1</strong> [P-X2.1.1]: Assess and document the capacity and usage data for current nurse line. Baseline: Triage calls report showed Pediatrics scheduled 11,593 visits; Internal Medicine scheduled 980 visits Data Source: Assessment report</td>
<td><strong>Milestone 5</strong> [P-5.]: Establish a multilingual nurse advice line <strong>Metric 1</strong> [P-5.1.1]: Number of bilingual nurses staffing advice line per shift Goal: A minimum of 1 bilingual nurses to be on each shift Data Source: HR documents or other documentation demonstrating</td>
<td><strong>Milestone 8</strong> [P-X3]: Establish a baseline, in order to measure improvement over self <strong>Metric 1</strong> [P-X3.1.1]: Number of patients given appointment when needed Goal: Establish baseline for number/percent of patients calling the nurse triage line who get an urgent medical appointment by the next day. Data Source: Needs assessment report</td>
<td><strong>Milestone 11</strong> [I-14.1]: Increase patients in defined population who utilized the nurse advice line and were given an urgent medical appointment via the nurse advice line when needed <strong>Metric 1</strong> [I-14.1.1]: Number of urgent medical appointments scheduled via the nurse advice line Goal: Increase by 10% the number of patients given an urgent medical appointment via the nurse advice line. An urgent medical appointment is defined as having given an appointment via the nurse line for no</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td><strong>Milestone 3 [P-3]: Train nurses on clinical protocols</strong></td>
<td><strong>Metric 1 [P-3.1.]: Number of nurses trained</strong> Baseline/Goal: Hire 12 registered nurses Data Source: HR records.</td>
<td><strong>Milestone 5 Estimated incentive payment: $1,480,456</strong></td>
<td><strong>Milestone 9 [I-13.]: Increase in the number of patients that accessed the nurse advice line</strong> Goal: Increase by 40,000 answered calls over baseline, the number of calls answered, to a total of 60,390 calls Data Source: Call Center phone and encounter records and appointment scheduling software records</td>
</tr>
<tr>
<td>Milestone 1 Estimated incentive payment: $1,356,947</td>
<td><strong>Metric 1 [P-6.1.]: Number of targeted patients informed/educated</strong> Baseline: 0 (new program) Goal: 20,000 unique patients Data Source: Contact lists to include mailing lists, email lists, and patient schedules</td>
<td><strong>Metric 1 [I-13.1.]: Utilization of nurse advice line</strong> Goal: Increase by 40,000 answered calls over baseline, the number of calls answered, to a total of 60,390 calls Data Source: Call Center phone and encounter records and appointment scheduling software records</td>
<td><strong>Milestone 9 Estimated incentive payment: $1,591,608</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [P-3.1.]: Number of nurses trained</strong> Baseline/Goal: Hire 12 registered nurses Data Source: HR records.</td>
<td><strong>Metric 1 [P-6.1.]: Number of targeted patients informed/educated</strong> Baseline: 0 (new program) Goal: 20,000 unique patients Data Source: Contact lists to include mailing lists, email lists, and patient schedules</td>
<td><strong>Metric 1 [I-13.1.]: Utilization of nurse advice line</strong> Goal: Increase by 40,000 answered calls over baseline, the number of calls answered, to a total of 60,390 calls Data Source: Call Center phone and encounter records and appointment scheduling software records</td>
<td><strong>Milestone 9 Estimated incentive payment: $1,591,608</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [P-3.1.]: Number of nurses trained</strong> Baseline/Goal: Hire 12 registered nurses Data Source: HR records.</td>
<td><strong>Metric 1 [P-6.1.]: Number of targeted patients informed/educated</strong> Baseline: 0 (new program) Goal: 20,000 unique patients Data Source: Contact lists to include mailing lists, email lists, and patient schedules</td>
<td><strong>Metric 1 [I-13.1.]: Utilization of nurse advice line</strong> Goal: Increase by 40,000 answered calls over baseline, the number of calls answered, to a total of 60,390 calls Data Source: Call Center phone and encounter records and appointment scheduling software records</td>
<td><strong>Milestone 9 Estimated incentive payment: $1,591,608</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [P-3.1.]: Number of nurses trained</strong> Baseline/Goal: Hire 12 registered nurses Data Source: HR records.</td>
<td><strong>Metric 1 [P-6.1.]: Number of targeted patients informed/educated</strong> Baseline: 0 (new program) Goal: 20,000 unique patients Data Source: Contact lists to include mailing lists, email lists, and patient schedules</td>
<td><strong>Metric 1 [I-13.1.]: Utilization of nurse advice line</strong> Goal: Increase by 40,000 answered calls over baseline, the number of calls answered, to a total of 60,390 calls Data Source: Call Center phone and encounter records and appointment scheduling software records</td>
<td><strong>Milestone 9 Estimated incentive payment: $1,591,608</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [P-3.1.]: Number of nurses trained</strong> Baseline/Goal: Hire 12 registered nurses Data Source: HR records.</td>
<td><strong>Metric 1 [P-6.1.]: Number of targeted patients informed/educated</strong> Baseline: 0 (new program) Goal: 20,000 unique patients Data Source: Contact lists to include mailing lists, email lists, and patient schedules</td>
<td><strong>Metric 1 [I-13.1.]: Utilization of nurse advice line</strong> Goal: Increase by 40,000 answered calls over baseline, the number of calls answered, to a total of 60,390 calls Data Source: Call Center phone and encounter records and appointment scheduling software records</td>
<td><strong>Milestone 9 Estimated incentive payment: $1,591,608</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [P-3.1.]: Number of nurses trained</strong> Baseline/Goal: Hire 12 registered nurses Data Source: HR records.</td>
<td><strong>Metric 1 [P-6.1.]: Number of targeted patients informed/educated</strong> Baseline: 0 (new program) Goal: 20,000 unique patients Data Source: Contact lists to include mailing lists, email lists, and patient schedules</td>
<td><strong>Metric 1 [I-13.1.]: Utilization of nurse advice line</strong> Goal: Increase by 40,000 answered calls over baseline, the number of calls answered, to a total of 60,390 calls Data Source: Call Center phone and encounter records and appointment scheduling software records</td>
<td><strong>Milestone 9 Estimated incentive payment: $1,591,608</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [P-3.1.]: Number of nurses trained</strong> Baseline/Goal: Hire 12 registered nurses Data Source: HR records.</td>
<td><strong>Metric 1 [P-6.1.]: Number of targeted patients informed/educated</strong> Baseline: 0 (new program) Goal: 20,000 unique patients Data Source: Contact lists to include mailing lists, email lists, and patient schedules</td>
<td><strong>Metric 1 [I-13.1.]: Utilization of nurse advice line</strong> Goal: Increase by 40,000 answered calls over baseline, the number of calls answered, to a total of 60,390 calls Data Source: Call Center phone and encounter records and appointment scheduling software records</td>
<td><strong>Milestone 9 Estimated incentive payment: $1,591,608</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [P-3.1.]: Number of nurses trained</strong> Baseline/Goal: Hire 12 registered nurses Data Source: HR records.</td>
<td><strong>Metric 1 [P-6.1.]: Number of targeted patients informed/educated</strong> Baseline: 0 (new program) Goal: 20,000 unique patients Data Source: Contact lists to include mailing lists, email lists, and patient schedules</td>
<td><strong>Metric 1 [I-13.1.]: Utilization of nurse advice line</strong> Goal: Increase by 40,000 answered calls over baseline, the number of calls answered, to a total of 60,390 calls Data Source: Call Center phone and encounter records and appointment scheduling software records</td>
<td><strong>Milestone 9 Estimated incentive payment: $1,591,608</strong></td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount: $4,070,843** **Year 3 Estimated Milestone Bundle Amount: $4,441,367** **Year 4 Estimated Milestone Bundle Amount: $4,774,824** **Year 5 Estimated Milestone Bundle Amount: $4,657,637**

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $17,944,671
Project Option 1.1.1 – 1.1 Establish more primary care clinics: New Northwest Houston Primary Care Clinic

**Unique RHP Project ID:** 111810101.1.6  
**Performing Provider Name/TPI:** UTHealth, UTPhysicians / 111810101

**Project Summary:**

Provider: UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

**Intervention(s):**
UT Physicians will establish a new primary care clinic in the Northwest area of Houston. Space will be acquired for additional consulting, exam and procedure rooms. Additional providers and support staff will be added to provide primary care services, and the hours of service will be extended, including evenings and Saturdays.

**Need for the project:** This project addresses the county’s inadequate access to primary care and high rates of inappropriate emergency department utilization. For the fiscal year 2010, 10% of all potentially preventable hospitalizations (PPR) were ambulatory care sensitive. In 2009, 41% (390,945) of ED visits in Houston were primary care related (PCR), including non-urgent, primary care treatable, and primary care preventable, and for 26.8% (104,762) of these PCR visits, Medicaid was the payer.

**Target Population:** The number of people living below the FPL in the targeted 14 census tract areas is estimated to be approximately 32,891 (34.3% of the population in that area), who would either be on Medicaid, or are Medicaid-eligible.

**Category 1 or 2 expected patient benefits:** Our goal is to increase primary care clinic visits and improve access for patients seeking services. This will translate to better patient satisfaction with primary care services. By expanding primary capacity at our community clinics, we expect to deliver a total of **48,936** patient visits by the end of DY5 with at least **24,000** of these as Medicaid, or Medicaid-eligible, patients visits. However, this is a very conservative estimate, since all our expansion projects are targeting the low income populations in our service areas.

**Category 3 outcomes:**
Our goals are to reduce the impact of cancer by increasing early detection screenings for cervical cancer (IT-12.2), breast cancer (IT-12.1), and colorectal cancer (IT-12.3).
Project Option 1.1.1 – Establish more primary care clinics: New Northwest Houston Primary Care Clinic

**Unique RHP Project Identification Number:** 111810101.1.6  
**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Project Description:** 1.1 Expand Primary Care Capacity (Option 1.1.1)

UT Physicians (UTP) intends to address the shortage of primary and specialty care in Region 3. In this project, UTP will establish a new primary care clinic in Northwest Houston, which will provide primary care for the population in an area of Harris County that is between Halls Bayou to the north, Beltway 8 to the west, I-10W to the south, and the Hardy Toll Road to the east. UTP has defined the service area for this clinic as a priority area for pediatric services, because it contains 14 of the 81 census tracts that make up the top 10% of all census tracts in Harris County with the greatest number of people living below the federal poverty level (FPL). (The census tracts are 5333, 5331, 5321, 5320.01, 5307, 5223.01, 5221, 5214, 5206.02, 2217, 2216, 2215, 2214, and 2213.) The number of people living below the FPL in just these 14 census tract areas is estimated to be approximately 32,891 (34.3% of the population in that area), who would either be on Medicaid, or are Medicaid-eligible. This clinic will market services to this population and provide services to those who respond. The capacity of the clinic is expected to be over 20,000 patient visits per year. Using a very conservative estimate of 50% of these clinic visits being with Medicaid/Medicaid-eligible patients, we would see a total of at least 10,000 Medicaid primary care visits per year. (UT Physicians’ current payer mix for pediatrics includes a 60% mix of Medicaid and non-resource.) We estimate that we will have provided over 48,000 patient visits by the end of DY5, with approximately 24,000 of them being for patients on Medicaid, or who are Medicaid-eligible. Furthermore, these areas have particularly high numbers of Hispanics (64.6%), for whom language, as well as poverty, may pose a barrier to obtaining primary care for their children. Black/African Americans, another segment of the population that tend to be medically underserved, also make up a significant proportion of the population in these census tracts (20.4%). The service area for this clinic includes large populations with economic, cultural, language, and transportation barriers to receiving primary care. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties.) In order to address the unique needs of different communities in the greater Houston area, Memorial has chosen to establish a primary care clinic in this area as an independent DSRIP project.

In order to implement this project, UTP will lease additional space to open the new clinic. This space will include additional consulting, exam and procedure rooms. The clinic will offer expanded evening and weekend hours to improve access to low-wage workers, who often work in jobs that do not grant paid time off for illness, or healthcare related needs. UTP will recruit additional primary care providers and support staff to operationalize the project. UTP is uniquely positioned to attract and retain new physicians, because it is a part of the world-class academic and research institution, The University of Texas Health Science Center-Houston. Although the need in the defined service area for this project is so great that it could support many primary care clinics, there is currently only one community health clinic that serves the indigent population (Harris Health’s Aldine Health Center) and it is on the southern-most border
of our defined service area. Harris Health has not proposed any further clinics in this area, but
UTP will collaborate with them to ensure that our clinic is placed optimally to provide the
greatest convenience to the population without risking duplication of services provided by Harris
Health. Furthermore, since this primary care clinic will provide services to the adult population,
it will not duplicate services to be provided through Memorial Hermann Hospital’s proposed
Northwest Houston Pediatric Clinic, but rather complement these services.

**Goal and Relationship to Regional Goals:**

**Project Goals:**

Expand primary care capacity to better accommodate the needs of the regional patient
population and community, so that patients have enhanced access to the right health care
services, at the right time, in the right setting.

This project addresses the following regional goals:

One of the goals of the region is to "Increase access to primary and specialty care services,
with a focus on underserved populations, to ensure patients receive the most appropriate care for
their condition, regardless of where they live or their ability to pay". Expansion of primary care
capacity certainly relates to this goal as it will make it easier for UT Physicians to provide care to
underserved populations.

**Challenges:**

Need: 1) Inadequate access to primary care. 2) High rates of inappropriate emergency
department utilization.

Implementation: 1) Staff recruitment and retention. 2) Marketing of expansion.

By expanding the capacity of their clinics, UT Physicians will be better able to deliver
timely care to more patients when needed thereby diverting patients away from the emergency
room. UT Physicians will recruit physicians from the UTHealth residents placed at Memorial
Hermann Hospital-TMC and will offer them a competitive salary and other incentives to practice
in the outlying clinics. A marketing campaign that addresses the culture(s) and needs of the
community will be implemented to inform the community of our expanded capacity to provide
quality care that is convenient for them.

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

There will be shortening of waiting times for primary care appointments and increased
uptake of primary care services in this service area, which will increase the percentage of
patients who receive appropriate primary health care, including preventative services, regular
screenings, and monitoring for those patients with chronic illnesses. UT Physicians expects to
see an uptake of regular screenings particularly for breast cancer and colon cancer. Detecting
cancer early can reduce the burden of the disease in terms of both improved health outcomes and
lower costs. This project will benefit the Medicaid and low-income client base of this area,
which is estimated to be a minimum of 32,891 (but likely to be much higher based on the
demographics of the area). The expansion of service hours to nights and Saturdays will be of
particular benefit to those unable to see a physician during business hours. The increase in
primary care capacity, coupled with our transition to the team-based, proactive healthcare
delivery model of medical homes, all conveniently located where there is great need, will help to
address many of the barriers that the low-income population typically encounter in getting the
appropriate care, facilitating better health outcomes.
By expanding primary capacity at our community clinics, we expect to deliver a total of 48,936 patient visits by the end of DY5 with at least 24,000 of these as Medicaid, or Medicaid-eligible, patients visits. However, this is a very conservative estimate, since all our expansion projects are targeting the low income populations in our service areas.

**Starting Point/Baseline:**
UTHSC-H has identified the targeted service area needing increased access to primary care. Since this will be a new clinic, the baseline is 0. Targets for milestones and metrics are based upon the projected capacity of the clinic.

**Rationale:**
Research has shown that access to primary care is associated with better health outcomes at less cost. Access to primary care ensures better preventive care and better management of chronic disease, with lack of access often resulting in more expensive care, received in hospitals and emergency departments (ED). For the fiscal year 2010, 10% of all potentially preventable hospitalizations (PPR) were ambulatory care sensitive. In 2009, 41% (390,945) of ED visits in Houston were primary care related (PCR), including non-urgent, primary care treatable, and primary care preventable, and for 26.8% (104,762) of these PCR visits, Medicaid was the payor. Getting more patients into primary care will help to reduce the use of this more costly care. Placing more primary care providers out in the communities served by the UT Physicians will help to address transportation access barriers and the expansion of clinic service hours will provide a greater selection of available appointment times. By increasing primary care capacity and engaging more people in the primary care system, avoiding inappropriate utilization of costly services, the community will experience better health outcomes and greater patient satisfaction. (PPR rate was from the Texas Health and Human Services Commission report on Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal year 2010, published January, 2012. The statistics for ED use were from the Houston Hospitals Emergency Department Use Study (January 1, 2009 through December 31, 2009), Final Report, prepared by the UT School of Public Health, May 2011, included in the 2010 Harris County Community Needs Assessment for Memorial Hermann.)

**Project Components:**
Through the New North Harris County Healthcare Clinic, we propose to:

a) Identify and lease appropriate space within the defined service area to establish a new clinic.

b) Once leased, we will recruit primary care physicians and support staff.

c) The clinic will operate with expanded evening and Saturday hours to increase access.

**Milestones and Metrics:**
For the Expand Existing Primary Care Capacity at UT Physicians Clinics Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

**Process Milestones and Metrics:**
Milestone 1 [P-X]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign
Metric 1 [P-X.1]: Documentation of plan for the new clinic.

Milestone 2 [P-X]: Designate/hire personnel or teams to support and/or manage the project/intervention
Metric 1 [P-X.2]: Project managers, personnel assigned to teams, and team responsibilities

Milestone 3 [P-X3]: Conduct community outreach and marketing
Metric 1 [P-X3.1]: Conduct community outreach and marketing

Milestone 4 [P-1]: Establish an additional primary care clinic
Metric 1 [P-1.1]: Number of additional clinics.

Milestone 5 [P-5]: Hire additional primary care providers and staff
Metric 1 [P-5.1]: Documentation of increased number of providers and staff.

Milestone 7 [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours
Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline

Improvement Milestones and Metrics:

Milestone 6 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.
Metric 1 [I-12.1]: Documentation of increased number of visits (DY3). Demonstrate improvement over prior reporting period.

Milestone 9 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.
Metric 1 [I-12.1]: Documentation of increased number of visits (DY4). Demonstrate improvement over prior reporting period.

Milestone 10 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.
Metric 1 [I-12.1]: Documentation of increased number of visits (DY5). Demonstrate improvement over prior reporting period.

Milestone 11 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services
Metric 1 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period.

Milestone 12 [I-11]: Patient satisfaction with primary care services.
Metric 1 [I-11.1]: Improved Patient satisfaction scores

Unique community need identification numbers the project addresses:
This project addresses community needs CN.1 (Inadequate access to primary care) and CN.8 (High rates of inappropriate emergency department utilization).

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
UT Physicians operates 4 clinics that serve areas that include large populations with economic, cultural, language, and transportation barriers to receiving primary care. This project
proposes to add a new clinic in a different location where there is also a large population with economic, cultural, language, and transportation barriers to receiving primary care and where the demand for services is high. While this project is an expansion of UTP services in order to improve access to care, it is a new clinic in an area of great need.

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

**OD-12 Primary Care and Primary Prevention**
- IT-12.2 Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)
  Numerator: Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. Denominator: Women aged 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix are excluded.

**OD-12 Primary Care and Primary Prevention**
- IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)
  Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period. Denominator: Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded.

**OD-12 Primary Care and Primary Prevention**
- IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)
  Numerator: Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years
  Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.

**Relationship to other Projects:**
In addition to the UTP Pass-2 project for adding specialty services to this new primary care clinic in the North Harris County defined service area, in order to provide greater access to integrated care, this project is related to the below Pass 1 projects proposed by UT Physicians.

1.2 (A2, SPH1) - Increased training of primary care workforce will provide physicians and support staff needed to expand primary care capacity.

1.7 (A1) - Expanded primary care capacity will facilitate and enhance access to specialty care via telemedicine.

1.10 (MS1) - The systems engineering and user dashboards will give providers greater access to information and provide reports facilitating a continuous quality improvement process.

2.1 (C1-2) - As part of the medical home project, all patients will be assigned to a primary care provider within the UT Health medical home. Expanded primary care capacity will be a necessary step to making this possible.

2.2 (CL3, C5-C9) - Expanded capacity in primary care will ensure the availability of staff to implement the expansion of the chronic care management model for the targeted diseases.

2.11 (C10) - The medication management program will be an integral part of the coordinated care provided by the primary care physicians.

2.12 (A3, CL1, CL2, MS4) - For the various care transition projects to be successful, UT Health needs to ensure it has adequate primary care capacity to handle the increased volume of patients.
**Relationship to Other Performing Providers’ Projects in the RHP:**

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

**Plan for Learning Collaborative:**

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

**Project Valuation:**

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTP used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. **Transformational Impact** (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. **Population Served/Project Size** (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid

3. **Aligned with Community Needs** (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. **Cost Avoidance** (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects.

5. **Partnership/Collaboration** (Weight = 10%): *This was not rated*, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.
6. Sustainability (Weight = 15%): *This was also not rated*, because UTHealth does not consider any of the projects to be unsustainable or at the very least do not consider one project less sustainable than another. Giving the projects the same or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
<table>
<thead>
<tr>
<th><strong>111810101.1.6</strong></th>
<th><strong>OPTION 1.1.1</strong></th>
<th><strong>A-C</strong></th>
<th><strong>NEW NORTH HARRIS COUNTY HEALTHCARE CLINIC</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s):</strong></td>
<td><strong>111810101.1.10</strong></td>
<td><strong>IT-12.2</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>(10/1/2012 – 9/30/2013)</strong></td>
<td><strong>111810101.1.11</strong></td>
<td><strong>IT-12.1</strong></td>
</tr>
<tr>
<td><strong>Year 3</strong></td>
<td><strong>(10/1/2013 – 9/30/2014)</strong></td>
<td><strong>111810101.1.12</strong></td>
<td><strong>IT-12.3</strong></td>
</tr>
<tr>
<td><strong>Year 4</strong></td>
<td><strong>(10/1/2014 – 9/30/2015)</strong></td>
<td><strong>Year 5</strong></td>
<td><strong>(10/1/2015 – 9/30/2016)</strong></td>
</tr>
<tr>
<td><strong>Milestone 1</strong> [P-X1]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign</td>
<td><strong>Milestone 4</strong> [P-1]: Establish an additional primary care clinic</td>
<td><strong>Milestone 7</strong> [P-5]: Hire additional primary care providers and staff</td>
<td><strong>Milestone 10</strong> [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-X1.1]: Documentation of plan for the new clinic. Baseline/Goal: Implementation plan (eligibility criteria, implementation components, responsibilities, and timeline). Data Source: UT Physicians' documents.</td>
<td><strong>Metric 1</strong> [P-1.1]: Number of additional clinics. Goal: 1 new clinic Data Source: New primary care schedule and other UT Physicians' documents.</td>
<td><strong>Metric 1</strong> [P-5.1]: Documentation of increased number of providers and staff. Baseline/Goal: Hire 1 FTE physicians; 1 FTE NP’s; 1 support staff Data Source: UT Physicians' report, policy, contract or other documentation</td>
<td><strong>Metric 1</strong> [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase of 898 patient visits over previous reporting period for a total of 19,116 patient visits for DY5 Data Source: Registry, EHR, claims or other UT Physicians’ source.</td>
</tr>
<tr>
<td>Milestone 1 Estimated incentive payment: $1,372,912</td>
<td>Milestone 4 Estimated incentive payment: $1,498,461</td>
<td>Milestone 7 Estimated incentive payment: $1,610,333</td>
<td>Milestone 10 Estimated incentive payment: $1,570,471</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-X2]: Designate/hire personnel or teams to support and/or manage the project/intervention</td>
<td><strong>Milestone 5</strong> [P-5]: Hire additional primary care providers and staff</td>
<td><strong>Milestone 8</strong> [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours</td>
<td><strong>Milestone 11</strong> [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-X2.1]: Project managers, personnel assigned to teams, and team responsibilities Baseline/Goal: 1 Project Manager; 3 support personnel; Data Source: Program Documentation</td>
<td><strong>Metric 1</strong> [P-5.1]: Documentation of increased number of providers and staff. Baseline/Goal: Hire 2 FTE physicians; 2 FTE NP’s; 2 nurses; 4 support staff Data Source: HR documents, UT Physicians' report, policy, contract or other documentation</td>
<td><strong>Metric 1</strong> [P-4.1]: Increased number of hours at primary care clinic over baseline Baseline/Goal: Add 4 hours Saturday and 2 evening clinics (6hrs) Data Source: Clinic documentation</td>
<td><strong>Metric 1</strong> [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. Goal: Increase by 10% the number of unique patients Data Source: Registry, EHR, claims</td>
</tr>
<tr>
<td>Milestone 2 Estimated incentive payment: $1,372,912</td>
<td>Milestone 5 Estimated incentive payment: $1,498,460</td>
<td>Milestone 8 Estimated incentive payment: $1,610,333</td>
<td>Milestone 11 Estimated incentive payment: $1,570,471</td>
</tr>
<tr>
<td><strong>Milestone 6</strong> [I-12]: Increase primary care clinic volume of visits and visits and evidence of improved access for patients seeking services</td>
<td><strong>Milestone 9</strong> [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services</td>
<td><strong>Milestone 10</strong> Estimated incentive payment: $1,570,471</td>
<td><strong>Milestone 11</strong> Estimated incentive payment: $1,570,471</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase of 898 patient visits over previous reporting period for a total of 19,116 patient visits for DY5 Data Source: Registry, EHR, claims or other UT Physicians’ source.</td>
<td><strong>Metric 2</strong> [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. Goal: Increase by 10% the number of unique patients Data Source: Registry, EHR, claims</td>
<td><strong>Milestone 11</strong> Estimated incentive payment: $1,570,471</td>
<td><strong>Milestone 11</strong> Estimated incentive payment: $1,570,471</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)</td>
<td>evidence of improved access for patients seeking services.</td>
<td>care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td>or other UT Physicians’ source.</td>
</tr>
<tr>
<td>Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)</td>
<td>Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase of 11,602 patient visits over baseline, and total for DY3. Data Source: Registry, EHR, claims or other UT Physicians' source</td>
<td>Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase of 6,616 patient visits over DY3, for a total of 18,218 patient visits for DY4. Data Source: Registry, EHR, claims or other UT Physicians' source</td>
<td>Milestone 11 Estimated incentive payment: $1,570,470</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)</td>
<td>Metric 1 [I-12.3]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase of 6,616 patient visits over DY3, for a total of 18,218 patient visits for DY4. Data Source: Registry, EHR, claims or other UT Physicians' source</td>
<td>Milestone 9 Estimated incentive payment: $1,610,332</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3 [P-X3]: Conduct community outreach and marketing</strong></td>
<td><strong>Metric 1 [P-X3.1]: Conduct community outreach and marketing</strong></td>
<td><strong>Goal: Reach all households in targeted service areas with a bi-lingual mailer announcing services to be provided at the new clinic</strong></td>
<td><strong>Metric 1 [I-11.1]: Improved Patient satisfaction scores</strong> Baseline: Overall Mean Score is 87.6; Ability to get appointment when wanted is 82.7 Goal: A statistically significant increase at the 95% confidence level in both the overall mean score for patient satisfaction and in the score for ability to get appointment when wanted. Data Source: CG-CAHPS3 or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population.</td>
</tr>
<tr>
<td><strong>Data Source: Mailing list, mailing contract, mailer</strong> Milestone 3 Estimated incentive payment: $1,372,912</td>
<td><strong>Milestone 6 Estimated incentive payment: $1,498,460</strong></td>
<td><strong>Milestone 9 Estimated incentive payment: $1,610,332</strong></td>
<td><strong>Milestone 12 Estimated incentive payment: $1,570,470</strong></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $4,118,736</td>
<td>Year 3 Estimated Milestone Bundle Amount: $4,495,381</td>
<td>Year 4 Estimated Milestone Bundle Amount: $4,830,998</td>
<td>Year 5 Estimated Milestone Bundle Amount: $4,711,411</td>
</tr>
</tbody>
</table>
### Option 1.1.1

**A-C**

**New North Harris County Healthcare Clinic**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>111810101.3.10</td>
<td>IT-12.2</td>
<td>Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>111810101.3.11</td>
<td>IT-12.1</td>
<td>Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>111810101.3.12</td>
<td>IT-12.3</td>
<td>Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Estimated Incentive Payments for 4-Year Period:** $18,156,526
Project Option 1.9.2- 1.9 Expand Specialty Care Capacity: Expand UT Physician Specialty Services to Outlying Clinics

**Unique RHP Project ID:** 111810101.1.7  
**Performing Provider Name/TPI:** UTHealth, UTPhysicians / 111810101

**Project Summary:**

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
UT Physicians will recruit specialists for each of its outlying clinics. Clinic service hours will be extended to provide evening and weekend appointment options. Standardized referral systems will be put in place to ensure access to these specialists.

Need for the project:
Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems, and our region has problems of access to specialty care as reflected in the regional community needs assessment.

Target Population:
The service areas of our 4 outlying clinics include large populations with economic, cultural, language, and transportation barriers to receiving primary care. Using the Harris County rate (14.5%) of Medicaid clients, there are an estimated 1,423,176 Medicaid clients living within the tightly-defined service areas of the UT Physician Clinics. With a minimum of 4 FTE specialty providers, we expect to reach approximately 38,000 specialty patient visits by DY5.

Category 1 or 2 expected patient benefits:
The DY4 goal is to increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties, and by DY5 to increase the number of referrals of targeted patients to the specialty care clinic. By expanding primary capacity at our community clinics, we expect to deliver at least 32,982 patient visits by the end of DY5 with at least 7,586 of these being Medicaid visits, which is expected to be much higher.

Category 3 outcomes:
IT-1.1: Our target is to reduce by 1 day over baseline in DY4, and by 2 days in DY5, the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The
ultimate goal is to decrease number of days to third next available appointment to two days for Specialty Care.
Project Option 1.9.2 – Expand Specialty Care Capacity: Expand UT Physician Specialty Services to Outlying Clinics

Unique RHP Project Identification Number: 111810101.1.7
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 1.9 Expand Specialty Care Capacity (Option 1.9.2)

UT Physicians (UTP) will recruit specialists for each of its outlying clinics, based upon the specialty care gap assessment to be conducted for each of our community primary care clinic service areas. Due to the high demand for services from specialists at clinics in the area, patients wait a long time (as much as 4-6 months) to receive consultation, and it is inconvenient and expensive to travel to specialty clinics. We intend to place at least 1 FTE specialist at each of the 4 UTP clinics described below, but expect that the gap assessment will identify a need for more than 1 specialty at some of the clinics (particularly the two clinics providing service in the Ft. Bend County area, where there is a dearth of specialty providers). We expect to see a need for endocrinologists, pulmonologists, and cardiologists, but will accommodate other specialties, depending upon the outcome of the gap assessment. This will enable expansion of UT Health specialties in areas outside the Texas Medical Center and into other areas where economic and transportation barriers exist and where there is a great need for ambulatory care (see below description of UTP service areas targeted by this project). At a minimum of 4 FTE specialists, this expansion would enable approximately 15,200 patient visits per year (based on 3,800/yr/specialist FTE), with a potential to reach over 38,000 patient visits by the end of DY5. Clinic service hours will be extended including evening and weekend appointment options in order to further increase access to these services. Standardized referral systems will be put in place to ensure access to these specialists.

Additionally, where there is a need for multiple specialties in the community clinics, where further space expansion might be limited, we will provide access to the UT Health Regional Multispecialty Physician Group via telemedicine. We propose to develop a rapid e-mail and/or internet based/technologically driven consultation process to manage complicated diabetes and other patients of the primary care community clinics who would otherwise require a referral to specialists in the Texas Medical Center. We will recruit specialists, physician assistants and nurse practitioners to manage the process.

Also, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project to ensure that we are delivering the right care to those in need, where it is needed. We will also use these QI processes to identify challenges for further expansion and to build on lessons learned.
UT will market the availability of specialty services to the UTP clinic service areas, which has been defined as the Census Tracts within a seven-mile radius of the clinic, which includes large numbers of medically underserved, low income, and Medicaid/Medicaid-eligible populations. The Bayshore Clinic is in the southeast area of Houston and includes parts of Pasadena, South Houston, and areas immediately south of the ship channel. The service area of this clinic has a population of 431,199, with 36.5% living at/below the federal poverty level (FPL). The population is 49.2% Hispanic and of those, 51.1% are not proficient in English. The Bellaire Clinic, with a population of 472,698, is on the west side of Houston and also has a large minority population, with 24.1% Black/African American and 46% Hispanic, and 52.2% live at/below the FPL. Of the Spanish-speaking population in the Bellaire Clinic service area, 62.8% are not proficient in English. The Cinco Ranch (population 287,744) and Sienna Village (population 231,535) clinics serve populations reaching into Ft. Bend County that closely mirror the overall county demographics, with the exception of Sienna Village Clinic, which has a large Black/African American population of 33.5%. There are 20.8% of the Cinco Ranch Clinic population and 26.2% of the Sienna Village Clinic population living at/below the FPL. These two clinics also serve rural populations. Furthermore, according to a 2011 report of the Texas Medical Board, Ft. Bend County has a dearth of specialty providers compared to Harris County (76.5 fewer per 100,000 population) and the Texas average (44.1 fewer per 100,000 population). The service areas of these 4 clinics include large populations with economic, cultural, language, and transportation barriers to receiving primary care. Using the Harris County rate (14.5%) of Medicaid clients, there are an estimated 1,423,176 Medicaid clients living within the service areas of the UT Physician Clinics. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties. The Medicaid rate is from the U.S. Census Bureau and the Centers for Disease Control and Prevention, State and County by Demographic and Income Characteristics. SAHIE, 2009.)

Goal and Relationship to Regional Goals:

Project Goal:
To increase the capacity to provide specialty care services and the availability of targeted specialty providers to better accommodate the high demand for specialty care services so that patients have increased access to specialty services.

This project addresses the following regional goal:

The region aims to "Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay." By expanding specialty care services, patients will have greater access to specialty care when needed.

Challenges:
Need: 1) Inadequate access to specialty care. 2) Insufficient access to care coordination and integrated care treatment programs.
Implementation: 1) Staff recruitment and retention. 2) Coordination of specialty care and primary care appointments.

As the physician practice arm of the world-class academic and research institution, University of Texas Health Science Center-Houston, UTP is uniquely positioned to attract and retain new physicians. Also, since the UTP primary care clinics are already established, the integration of specialty care services will be a smoother transition than establishing completely new clinics. All providers and staff will be trained and a quality improvement process will be put in place to ensure that we achieve optimum coordination of services.

5-Year Expected Outcome for Provider and Patients:

There will be shortening of waiting times for specialty care appointments, such as for cardiology care, and better disease management for those with targeted chronic diseases. In addition to benefiting UTP’s current Medicaid population (23% as of 2011, or 65,302 patient visits), these expanded services will be available to the low-income client base of UTP clinics, particularly the additional Medicaid and Medicaid-eligible residents (1,423,176) living within the service areas of the UT Physician Clinics. The expansion of service hours to nights and Saturdays will be of particular benefit to those unable to see a physician during business hours. The increase in specialty care capacity, coupled with our transition to the team-based, proactive healthcare delivery model of medical homes, all conveniently located where there is great need, will help to address many of the barriers that the low-income population typically encounter in getting the appropriate care, facilitating better health outcomes. While positive outcomes are expected for each area of specialty care offered, we will specifically be monitoring the increased access to cardiology care for patients at risk of, or with heart disease. It is expected that increased access to cardiology care for these patients will result in increased cholesterol screening, better management of heart disease, and lower LDL-C rates.

By expanding primary capacity at our community clinics, we expect to deliver at least 32,982 patient visits by the end of DY5. At our current payer mix of 23% Medicaid, at least 7,586 of these would be Medicaid visits. However, this is a very conservative estimate, since all our expansion projects are targeting the low income populations in our service areas that are either on Medicaid, or are Medicaid-eligible. These numbers only reflect the minimum 4 FTE specialists and not the additional patient visits that would occur via the telemedicine option, where needed.

Starting Point/Baseline:
The types of specialties provided will depend on the outcome from the needs assessment. The baseline will have to be established during DY3. Targets are based upon the expanded capacity planned for the minimum number of FTEs to be provided.

Rationale:
Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems, and our region has problems of access to specialty care as reflected in the regional community needs assessment. To achieve success as an integrated network, this gap must be thoroughly addressed by expanding specialty care services to underserved populations. The availability of specialists to provide care in this area will allow patients to access care where
and when needed, thereby potentially reducing the need for emergency care, complications, and hence improve the overall health and wellbeing of the community.

**Project Components:**
Through the Expand UT Physician Specialty Services to Outlying Clinics Program, we propose to meet all required project components listed below.

a) UTP will conduct a specialty care gap assessment for the service areas of our primary care clinics.
b) UTP will recruit specialists of the type identified in the gap assessment to provider specialty services in the UTP primary care clinics.
c) Space will be identified and secured at the primary care clinics and additional support staff recruited to support the provision of specialty care in each of the clinics.
d) UTP will provide specialty services in the primary care clinics, which will include extended evening and Saturday hours.
e) UTP will implement transparent, standardized referrals across the system.
f) UTP will implement a telemedicine program for community clinics where both a demand for multiple specialists and space limitations exists.
g) UTP’s quality improvement office will conduct QI for each of the clinics providing specialty care using methods such as rapid cycle improvement.

**Milestones and Metrics:**
For the Expand UT Physician Specialty Services to Outlying Clinics Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

**Process Milestones and Metrics:**

**Milestone 1 [P-1.]:** Conduct specialty care gap assessment based on community need  
**Metric 1 [P-1.1.]:** Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2).

**Milestone 2 [P-3.]:** Collect baseline data for wait times, backlog, and/or return appointments in specialties  
**Metric 1 [P-3.1.]:** Establish baseline for performance indicators

**Milestone 3 [P-6.]:** Develop and implement standardized referral and work-up guidelines  
**Metric 1 [P-6.1.]:** Referral and work-up guidelines

**Milestone 4 [P-5.]:** Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment  
**Metric 1 [P-5.1.]:** Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians.

**Milestone 5 [P-11]:** Launch/expand a specialty care clinic  
**Metric 1 [P-11.1]:** Establish/expand specialty care clinics

**Milestone 6 [I-23.]:** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.  
**Metric 1 [I-23.1.]:** Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2).

**Milestone 7 [P-5.]:** Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment
Metric 1 [P-5.1.]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians).

**Milestone 8** [P-21.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

Metric 1 [P-21.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP

**Milestone 11** [P-5.]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment

Metric 1 [P-5.1.]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians)

**Milestone 12** [P-21.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

Metric 1 [P-21.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Improvement Milestones and Metrics:**

**Milestone 9** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties

Metric 1 [I-22.1.]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties

**Milestone 10** [I-23.]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

Metric 1 [I-23.1.]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2)

**Milestone 13** [I-23.]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

Metric 1 [I-23.1.]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (DY4).

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

This project addresses community needs CN.2 (Inadequate access to specialty care) and CN.7 (Insufficient access to care coordination practice management and integrated care treatment programs).

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

Currently, only 2 out of our 4 outlying clinics provide specialty care to patients, and even in these clinics the specialist services provided are limited. Thus this project will enhance our capacity to deliver specialty care, and represents a significant expansion of an existing program. This expansion is needed in the service areas of these clinics, which serve areas that include large populations with economic, cultural, language, and transportation barriers to receiving care.

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

OD-1 Primary Care and Chronic Disease Management

- IT-1.1 Third next available appointment (Non- standalone measure)
Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient, or return visit/exam. The goals will be to decrease number of days to third next available appointment to two days for Specialty Care.

OD-1 Primary Care and Chronic Disease Management

- IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure)
  Increase the number of patients who had each of the following during the reporting period:
  - Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed during the measurement year.
  - LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL.

**Relationship to other Projects:**

2.2 (C5-9, CL3) - This project will ensure that chronic care patients get specialist input into their care when needed, without the current delays being experienced.

2.11 (C10) - The medication management project will serve as a useful resource to every provider involved in managing the enrolled patients, to ensure optimum outcomes.

2.12 (A3, CL1, CL2, MS4) - The expansion of specialty care into the primary care settings will complement the care transition projects to ensure that patients get the right care at the right time.

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

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

**Plan for Learning Collaborative:**

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

**Project Valuation:**

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score.
(value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria and the reasons two of the criteria were not used:

1. **Transformational Impact** (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. **Population Served/Project Size** (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.

3. **Aligned with Community Needs** (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. **Cost Avoidance** (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects.

5. **Partnership/Collaboration** (Weight = 10%): *This was not rated*, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. **Sustainability** (Weight = 15%): *This was also not rated*, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
<p>| Related Category 3 Outcome Measure(s): | 111810101.3.13 | IT-1.1 | Third next available appointment (Non-standalone measure) |
| Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure) |
| Year 2 (10/1/2012 – 9/30/2013) | Year 3 (10/1/2013 – 9/30/2014) | Year 4 (10/1/2014 – 9/30/2015) | Year 5 (10/1/2015 – 9/30/2016) |
| <strong>Milestone 1</strong> [P-1.]: Conduct specialty care gap assessment based on community need | <strong>Milestone 4</strong> [P-11]: Launch/expand a specialty care clinic | <strong>Milestone 7</strong> [P-5.]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment | <strong>Milestone 11</strong> [P-5.]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment |
| Metric 1 [P-1.1.]: Documentation of gap assessment. Goal: Gap assessment will show what specialties need to be recruited in the area. Data Source: Needs Assessment | Metric 1 [P-11.1]: Establish/expand specialty care clinics Baseline/Goal: Hire 2 FTE providers and 2 support staff Data Source: Documentation of new/expanded specialty care clinic Milestone 4 Estimated incentive payment: $ 1,588,484 | Metric 1 [P-5.1.]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians). Goal: Keep wait times to next clinic day from completion of referral; referral process completed within 48 hours 90% of the time. Data Source: EHR, Referral Management system, Administrative records. (Generated Reports on file). Milestone 7 Estimated incentive payment: $1,277,968 | Metric 1 [P-5.1.]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians). Goal: Keep wait times to next clinic day from completion of referral; referral process completed within 48 hours 95% of the time. Data Source: EHR, Referral Management system, Administrative records. (Generated Reports on file). Milestone 11 Estimated incentive payment: $1,660,094 |
| Milestone 2 Estimated incentive payment: $ 1,452,733 | <strong>Milestone 5</strong> [P-5.]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment | <strong>Milestone 8</strong> [P-21.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-21.1.]: Participate in | <strong>Milestone 12</strong> [P-21.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-21.1.]: Participate in |
| <strong>Milestone 2</strong> [P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties | <strong>Milestone 6</strong> [P-5.]: Develop and implement standardized referral and work-up guidelines | <strong>Milestone 9</strong> [P-5.]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment | <strong>Milestone 13</strong> [P-5.]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment |
| Metric 1 [P-2.1]: Training of staff and providers on referral guidelines, process and technology | Milestone 5 Estimated incentive payment: $ 1,588,484 | Metric 1 [P-5.1.]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians). Goal: Keep wait times to next clinic day from completion of referral; referral process completed within 48 hours 90% of the time. Data Source: EHR, Referral Management system, Administrative records. (Generated Reports on file). Milestone 7 Estimated incentive payment: $1,277,968 | Metric 1 [P-5.1.]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians). Goal: Keep wait times to next clinic day from completion of referral; referral process completed within 48 hours 95% of the time. Data Source: EHR, Referral Management system, Administrative records. (Generated Reports on file). Milestone 11 Estimated incentive payment: $1,660,094 |
| Milestone 2 Estimated incentive payment: $ 1,452,732 | <strong>Milestone 7</strong> [P-5.]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment | <strong>Milestone 10</strong> [P-5.]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment | <strong>Milestone 14</strong> [P-5.]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment |
| <strong>Milestone 3</strong> [P-6]: Develop and implement standardized referral and work-up guidelines | <strong>Milestone 8</strong> [P-5.]: Develop and implement standardized referral and work-up guidelines | <strong>Milestone 11</strong> [P-5.]: Develop and implement standardized referral and work-up guidelines | <strong>Milestone 15</strong> [P-5.]: Develop and implement standardized referral and work-up guidelines |</p>
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>111810101.3.13 IT-1.1 111810101.3.14 IT-1.6</td>
<td>Milestone 5 Estimated incentive payment: $1,588,483</td>
<td>semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: attend 2 meetings per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>Milestone 8 Estimated incentive payment: $1,277,968</td>
<td>Milestone 12 Estimated incentive payment: $1,660,093</td>
</tr>
<tr>
<td><strong>Metric 1 [P-6.1.]:</strong> Referral and work-up guidelines Goal: Update, create and train staff on policies and procedures Data Source: Referral and work-up policies and procedures documents</td>
<td><strong>Milestone 6 [I-23.]:</strong> Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td><strong>Milestone 9 [I-22]:</strong> Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties</td>
<td><strong>Milestone 9 Estimated incentive payment: $1,277,967</strong></td>
<td><strong>Milestone 13 Estimated incentive payment: $1,660,093</strong></td>
</tr>
<tr>
<td>Milestone 3 Estimated incentive payment: $1,452,732</td>
<td><strong>Metric 1 [I-23.1.]:</strong> Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Increased specialty care visits by 6,571 over prior reporting period Data Source: Registry, EHR, claims or other Performing Provider source</td>
<td><strong>Milestone 6 Estimated incentive payment: $1,588,483</strong></td>
<td><strong>Milestone 13 [I-23.]:</strong> Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td><strong>Metric 1 [I-23.1.]:</strong> Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Increase specialty care visits by 978 visits for a total of 13,694 Data Source: Registry, EHR, claims or other Performing Provider source</td>
</tr>
<tr>
<td><strong>Milestone 6 Estimated incentive payment: $1,588,483</strong></td>
<td><strong>Milestone 6 [I-23.]:</strong> Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td><strong>Milestone 9 Estimated incentive payment: $1,277,967</strong></td>
<td><strong>Milestone 13 Estimated incentive payment: $1,660,093</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Expand UT Physician Specialty Services to Outlying Clinics

**UTHealth, UTPhysicians**

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

| Related Category 3 | Outcome Measure(s): | 111810101.3.13 | IT-1.1 | Third next available appointment (Non-standalone measure)  
Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure) |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>111810101.3.14</td>
<td>IT-1.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 10** [I-23.]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.

**Metric 1** [I-23.1.]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Increase specialty care visits by 6,146 visits for a total of 12,717 specialty care visits for DY4

Data Source: Registry, EHR, claims or other Performing Provider source

Milestone 10 Estimated incentive payment: $1,277,967

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $4,358,197</th>
<th>Year 3 Estimated Milestone Bundle Amount: $4,765,450</th>
<th>Year 4 Estimated Milestone Bundle Amount: $5,111,870</th>
<th>Year 5 Estimated Milestone Bundle Amount: $4,980,280</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $19,215,797
Project Option 1.10.2- 1.10 Enhance Performance Improvement and Reporting Capacity: UT Health Regional Systems Engineering Center and UT Health Quality Improvement (QI) Dashboard Development Center

Unique RHP Project ID: 111810101.1.8
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider: UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s): The project will develop a regional systems engineering center, that will recruit systems engineers to integrate with healthcare QI teams to cross train in applying systems engineering science to healthcare processes, and develop interdisciplinary courses for healthcare professionals, students, engineers and administrative healthcare leadership. The project will also develop QI capacity at UT Health by developing specialty-specific QI dashboards that will integrate QI data from various institutions, measure, report monthly specialty specific data, and serve as the engine to drive, conduct and rapidly diffuse quality and patient safety improvements.

Need for the project: Performance improvement and reporting is a large component of success of all of the project areas across the DSRIP project categories. The majority of medical errors result from faulty systems and processes, not individuals; because of this reason it is important to adopt process improvement techniques to identify inefficiencies, ineffective care, and preventable errors.

Target Population: With the expansion of primary and specialty care access to a potential population of another 1,423,176 Medicaid and Medicaid-eligible clients, we expect to provide access to an additional 80,000 patient visits, most of which are expected to be Medicaid/Medicaid-eligible clients (based on the demographics of the UTP clinics service areas).

Category 1 or 2 expected patient benefits:

By adopting various process improvement techniques to identify inefficiencies, ineffective care, and preventable errors, patients of UT Physicians will be safer and experience better health outcomes including fewer potentially preventable admissions/readmissions. These improvements will benefit all of UT Physicians patients, visits for which is expected to number approximately 400,000 per year by DY5, with at least 92,000 of them being for Medicaid patients.

Category 3 outcomes:
IT-4.8: Our goal is to reduce the percentage of patients expiring with sepsis, severe sepsis, or septic shock and/or an infection and organ dysfunction.
Project Option 1.10.2 – Enhance Performance Improvement and Reporting Capacity: UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center

Unique RHP Project Identification Number:  111810101.1.8
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description:  1.10 Enhance Performance Improvement and Reporting Capacity (Option 1.10.2)

UT Health proposes to develop a regional systems engineering center that will embed proven evidence-based industrial and systems engineering improvement methods such as Lean, Six Sigma, and Care Logistics into local healthcare organizations, starting with the Memorial Hermann System of Hospitals and the UT Physicians’ network of clinics, to significantly improve care, reduce errors, reduce cost, improve safety and overall quality of healthcare delivered to our patients. UT Health already has state-of-the-art top-ranking Regional Centers of Excellence in Dental Health, Maternal-Fetal Health, Women, Child and Adolescent Health, Healthy Aging, Neurosciences, Sports Medicine, Trauma and Rehabilitation, Behavioral and Mental Health, and Cardiovascular Medicine, and we will collaborate with Harris Health System’s proposed Center of Innovation to implement quality improvements throughout the region. The center will recruit systems engineers that will integrate with healthcare quality improvement teams to cross train in applying systems engineering improvement science to major healthcare processes, and develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement. The center will also develop interdisciplinary courses for healthcare professionals, students, engineers and administrative healthcare leadership. The center will review major quality improvement projects, including the quality improvement components of other UT Health DSRIP projects, and partner with quality improvement teams to embed industrial and systems engineering methodology into the design.

In addition, the project will develop quality improvement capacity at UT Health by developing specialty-specific quality improvement dashboards through a central center that will integrate quality improvement (QI) data from various institutions and national reporting agencies, measure, report monthly specialty specific data, and serve as the engine to drive, conduct and rapidly diffuse quality and patient safety improvements. The center will interface with various sites (Harris Health System, Memorial Hermann Hospital System, UT Physicians outpatient centers) to obtain clinical data to populate the Quality Dashboards that will be developed for each clinical specialty based on specialty specific key quality metrics (CMS, AHRQ, etc). Through the Quality Dashboards, UT Health will measure, report, support quality improvement projects and drive change with rapid diffusion of key successful process between departments and between organizations.

Goal and Relationship to Regional Goals:
Project Goal:
To expand quality improvement capacity throughout the organization so that the resources are in place to conduct, report, drive and measure quality improvement, and to implement process improvement methodologies to improve safety, quality, and efficiency.
This project addresses the following regional goal:

This project is anchored on the regional goal that aims to "develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes." This will be achieved partly by establishing learning processes and putting in place mechanisms for effective application and sharing of QI lessons learned.

Challenges:

Need: 1) High rates of preventable hospital admissions. 2) High rates of preventable hospital readmissions.

Implementation: 1) Recruitment and retention of systems engineers. 2) Training of systems users. 3) Willingness of regional health institutions to collaborate on QI partnerships

This project will put quality at the forefront of the health care transformation agenda in the region. Potentially preventable hospital admissions and readmissions are few of the manifestations of failure the system to provide quality care. Such issues are what the quality improvement processes that will be ushered in by this project will address. The project will also create the avenue for different health care organizations in the region to collaborate on quality improvement.

5-Year Expected Outcome for Provider and Patients:

By adopting various process improvement techniques to identify inefficiencies, ineffective care, and preventable errors, patients of UT Physicians, including the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base, will be safer and experience better health outcomes including fewer potentially preventable readmissions and mortality due to sepsis. The other UTP projects will expand primary and specialty care access to an additional 80,000 patient visits, bringing the number provided by UTP to approximately 400,000 per year by DY5. At our current Medicaid patient mix of 23%, UTP would reach approximately 92,000 Medicaid patients. However, we expect our Medicaid patient mix to increase significantly based upon the demographics of the UTP clinic service areas and the targeted patient populations. This is the population expected to benefit from the quality improvement efforts implemented—benefits which would include reduced errors, reduced cost, improved safety, and improved overall quality of healthcare.

Starting Point/Baseline:

This program does not currently exist within UT Physicians and there is currently no staff dedicated to implementing proven evidence-based industrial and systems engineering improvement methods for improving care, reducing errors, reducing cost, improving safety and overall quality of healthcare delivered to our patients. However, using the current system, 4 reports are run each month that look at certain quality measures. Consequently, this will be used as our baseline for reporting where appropriate. Otherwise, the baseline would be zero.

Rationale:

Performance improvement and reporting is a very large component of success of all of the project areas across the DSRIP project categories. The health industry is in need of quality and safety improvement initiatives (Martin LA, Nelson EC, Lloyd RC, Nolan TW. Whole System
Quality health care is defined as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (AHRQ: Measures Sought for National Quality Measures Clearinghouse. Available at: http://www.ahrq.gov/qual/nqmcmeas.htm, accessed 10/11/12). According to the Institute of Medicine (IOM), the majority of medical errors result from faulty systems and processes, not individuals. Because errors are caused by system or process failures, it is important to adopt various process improvement techniques to identify inefficiencies, ineffective care, and preventable errors to then influence changes associated with systems. This is what this project aims to achieve for the UTHealth system and other health institutions in the region. Each of the various techniques involves assessing performance and using the findings to inform change. Strategies and tools for quality improvement include failure modes and effects analysis, Plan-Do-Study-Act, Six Sigma, Lean, and root-cause analysis, and these have been used successfully to improve the quality and safety of health care. (The Denver Health LEAN Academy: Lean Results. Available at: http://www.denverhealth.org/LEANAcademy/AboutLEANAcademy/CaseStudies.aspx)

Project Components: Through the UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center Program, we propose to meet all required project components listed below.

a) UTP will establish a performance improvement office to collect, analyze, and manage real-time data and to monitor the improvement trajectory and improvement activities across the UT Physicians’s delivery system.

b) UTP will recruit and/or train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement, and/or data and analytics staff for reporting purposes.

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

d) UTP will design data collection systems and processes to collect real-time data, which will be used to drive continuous quality improvement.

Milestones and Metrics: For the UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Milestone 1 [P-1]: Establish a performance improvement office to collect, analyze, and manage real-time data and to monitor the improvement trajectory and improvement activities across the UT Physicians’s delivery system

Metric 1 [P-1.1]: Documentation of the establishment of performance improvement office
Milestone 2 [P-X1]: Designate/hire personnel or teams to support and/or manage the project/intervention
Metric 1 [P-X1.1]: Project managers, personnel assigned to teams, and team responsibilities

Milestone 3 [P-X2]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign
Metric 1 [P-X2.1]: Complete the plan of how the systems engineering center will function

Milestone 4 [P-2]: Establish a program for trained experts on process improvements to mentor and train other staff, including front-line staff, for safety and quality care improvement. All staff trained in this program should be required to lead an improvement project in their department within 6 months of completing their training.
Metric 1 [P-2.1]: Train the trainer program established

Milestone 5 [P-6]: Train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends)
Metric 1 [P-6.1]: Increase number of staff trained in quality and efficiency improvement principles

Milestone 6 [P-1]: Establish a performance improvement office to collect, analyze, and manage real-time data and to monitor the improvement trajectory and improvement activities across the Performing Provider’s delivery system
Metric 1 [P-1.2]: Documentation that the performance improvement office is engaged in collecting, analyzing, and managing real-time data

Milestone 7 [P-9]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.
Metric 1 [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

Milestone 8 [P-1]: Establish a performance improvement office to collect, analyze, and manage real-time data and to monitor the improvement trajectory and improvement activities across the Performing Provider’s delivery system
Metric 1 [P-1.3]: Documentation of quality improvement activities implemented by the performance improvement office

Milestone 9 [P-2]: Establish a program for trained experts on process improvements to mentor and train other staff, including front-line staff, for safety and quality care improvement. All staff trained in this program would be required to lead an improvement project in their department within 6 months of completing their training.
Metric 1 [P-2.2]: Improvement projects led by staff trained through the train the trainer Program

Milestone 10 [P-9]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.
Metric 1 [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

Milestone 14 [P-9]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.
Metric 1 [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

Improvement Milestones and Metrics:

**Milestone 11 [I-7]:** Implement quality improvement data systems, collection, and reporting capabilities

Metric 1 [I-7.1]: Increase the number of reports generated through these quality improvement data systems

**Milestone 12 [I-7]:** Implement quality improvement data systems, collection, and reporting capabilities

Metric 1 [I-7.1]: Increase the number of reports generated through these quality improvement data systems

**Milestone 13 [I-8]:** Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures

Metric 1 [I-8.1]: Submission of quality dashboard or scorecard

Unique community need identification numbers the project addresses:

This project addresses community needs CN.9 (High rates of preventable hospital readmissions) and CN.10 (High rates of preventable hospital admissions).

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

This project represents a new initiative. UT Physicians have not previously had access to these types of tools and processes for quality improvement.

Related Category 3 Outcome Measure(s):

OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions

- IT-4.8 Sepsis mortality (Standalone measure)

Reduce the percentage of patients expiring during current month hospitalization with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.

Relationship to other Projects:

1.3 (C12) - The chronic disease registries created under project C12 will make available useful QI data that will be used to populate the QI dashboards this project (MS1) seeks to create.

2.1 (C1-2) - This project will enhance quality improvement processes that will aid in identifying opportunities for continuous improvement in the functioning of the medical homes.

2.2 (C5-9, CL3) - This project will aid in the adoption of a 'whole systems' approach to chronic disease management, enabling the implementation of a comprehensive and proactive approach to chronic care, in which the patient is kept in continuous contact with the care team.

2.11 (C10) - The QI initiatives that will result from the implementation of this project will interact with the medication management program for the reduction of medication errors and noncompliance, providing a system for continuous quality improvement.

2.12 (A3, CL1, CL2, MS4) - Transitions in setting of care—for example from hospital to home or nursing home, or from facility to home and community-based services—have been shown to be prone to errors. This project (MS1) relates with these 4 care transitions projects by
putting in place the right processes and systems to ensure that potential errors associated with care transitioning are avoided.

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

Innovation is key to the transformation of healthcare in our community. The consistency of innovation in our region allows for increased improvements based on research trends, patient need, and provider availability. The waiver funding allows for innovation in specific areas and all innovative projects included in the plan are similar in the fact of program redesigns for historic treatments, and focus to chronic condition outcome measures such as central line infections. The Region 3 initiative grid in the addendum can provide a side by side comparison of all projects that directly relate to innovation.

**Plan for Learning Collaborative:**

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

**Project Valuation:**

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UT Health used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. **Transformational Impact** (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. **Population Served/Project Size** (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.

3. **Aligned with Community Needs** (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. **Cost Avoidance** (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects.

5. **Partnership/Collaboration** (Weight = 10%): This was not rated, because UT Health planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.
6. **Sustainability** (Weight = 15%): *This was also not rated*, because UT Health does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>IT-4.8</th>
<th>Sepsis mortality (Standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong></td>
<td>(10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 1</strong></td>
<td>[P-1]: Establish a performance improvement office to collect, analyze, and manage real-time data and to monitor the improvement trajectory and improvement activities across the UT Physicians’s delivery system</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>[P-1.1]: Documentation of the establishment of performance improvement office</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal</strong>: Specifies office name, location, number of staff and staff designations, and organizational chart.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data source</strong>: HR documents, office policies and procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 1 Estimated incentive payment</strong>: $ 606,636</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 2</strong></td>
<td>[P-X1]: Designate/hire personnel or teams to support and/or manage the project/intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>[P-X1.1]: Project managers, personnel assigned to teams and roles, team responsibilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal</strong>: Designate clinician team leaders. Designate/hire 1 project manager; 2 system engineers; 1 six sigma; 2 IT personnel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 4</strong></td>
<td>[P-2]: Establish a program for trained experts on process improvements to mentor and train other staff, including frontline staff, for safety and quality care improvement. All staff trained in this program would be required to lead an improvement project in their department within 6 months of completing their training.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>[P-2.1]: Train the trainer program established</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal</strong>: Establish and document the specifics of the train the trainer program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: HR, training program materials (including documentation of the number of hours of training required).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 4 Estimated incentive payment</strong>: $475,679</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5</strong></td>
<td>[P-6]: Train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 8</strong></td>
<td>[P-1]: Establish a performance improvement office to collect, analyze, and manage real-time data and to monitor the improvement trajectory and improvement activities across the Performing Provider’s delivery system</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>[P-1.3]: Documentation of quality improvement activities implemented by the performance improvement office</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: Conduct and document quality improvement activities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Meeting minutes and project documentation describing QI activities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 8 Estimated incentive payment</strong>: $ 533,656</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 9</strong></td>
<td>[P-2]: Establish a program for trained experts on process improvements to mentor and train other staff, including frontline staff, for safety and quality care improvement. All staff trained in this program would be required to lead an improvement project in their</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 12</strong></td>
<td>[I-7]: Implement quality improvement data systems, collection, and reporting capabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>[I-7.1]: Increase the number of reports generated through these quality improvement data systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal</strong>: Increase by 3 reports per month to 10 reports per month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Quality improvement data systems documentation/reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 12 Estimated incentive payment</strong>: $ 710,090</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 13</strong></td>
<td>[I-8]: Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>[I-8.1]: Submission of quality dashboard or scorecard</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal</strong>: Create and share, with organizational leadership at all levels, a quality dashboard that includes outcome measures and patient satisfaction. Will be shared quarterly.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Quality improvement dashboard or scorecard</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan

Region 3 915
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>111810101.3.15</th>
<th>IT-4.8</th>
<th>Sepsis mortality (Standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data source: Program documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 2 Estimated incentive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>payment: $ 606,635</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3 [P-X2]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-X2.1]: Complete the plan of how the systems engineering center will function</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Complete and document center plans including goals, objectives and action plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data source: Program documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 3 Estimated incentive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>payment: $ 606,635</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data source: Program documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 5 Estimated incentive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>payment: $ 475,679</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 6 [P-1]: Establish a performance improvement office to collect, analyze, and manage real-time data and to monitor the improvement trajectory and improvement activities across the Performing Provider’s delivery system</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-1.2]: Documentation that the performance improvement office is engaged in collecting, analyzing, and managing real-time data</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Conduct and document the collection, analysis, and management of quality improvement data</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data source: Project documentation that describes the data being collected, the analysis being conducted, and the related questions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 6 Estimated incentive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>payment: $475,679</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data source: Program documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 9 Estimated incentive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>payment: $ 533,657</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 10 [P-9]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-9.1]: Participate in semiannual face-to-face meetings or seminars organized by the RHP.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: At least 2 meetings per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 10 Estimated incentive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>payment: $ 710,090</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Regional Healthcare Partnership Plan Region 3**
<table>
<thead>
<tr>
<th>111810101.1.8</th>
<th>1.10.2</th>
<th>A-C</th>
<th>UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTHealth, UTPhysicians</td>
<td>111810101</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 7 [P-9]:</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1 [P-9.1]:</strong> Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: At least 2 meetings per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 7 Estimated incentive payment: $475,679</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Milestone 11 [I-7]:** Implement quality improvement data systems, collection, and reporting capabilities | | | | |
| **Metric 1 [I-7.1]:** Increase the number of reports generated through these quality improvement data systems Baseline: 4 reports per month Goal: Increase by 3 reports per month to 7 reports per month Data Source: Quality improvement data systems documentation/reports | | | | |
| Milestone 11 Estimated incentive payment: $533,657 | | | | |

**Year 2 Estimated Milestone Bundle Amount:** $1,819,906  
**Year 3 Estimated Milestone Bundle Amount:** $1,902,716  
**Year 4 Estimated Milestone Bundle Amount:** $2,134,627  
**Year 5 Estimated Milestone Bundle Amount:** $2,130,270

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $7,987,519
The University of Texas Health Science Center - Houston

Pass 2
Project Option 1.1.1 – Establish more primary care clinics: New North Harris County Healthcare Clinic

**Unique RHP Project ID:** 111810101.1.9  
**Performing Provider Name/TPI:** UTHealth, UTPhysicians / 111810101

**Project Summary:**

Provider:  
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians (UTP) has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):  
UT Physicians will establish the North Harris County Primary Care Clinic. Space will be leased to open the clinic, which will include consulting, exam and procedure rooms. The clinic will offer expanded evening and weekend hours to improve access to care. Primary care providers and support staff will be recruited to operationalize the project.

Need for the project:  
UTP has defined the service area for this clinic as a priority for primary care services, because of its high rate of poverty. Although the need in the defined service area for this project is so great that it could support many primary care clinics, there is currently only one community health clinic that serves the indigent population.

Target Population:  
The target population are those living in an area of Harris County that is between FM 1960 to the north, Cypress Creek Pkwy to the Northwest, Veteran’s Memorial Drive to the west, Aldine Mail Route to the south, and Highway 59N to the east. The population in this area is estimated to be 196,900, out of which 48,244 persons are living below the federal poverty level.

Category 1 or 2 expected patient benefits:  
By expanding primary capacity in this community, we expect to deliver a total of 48,936 patient visits by the end of DY5, with at least 11,255 of these being Medicaid visits. However, this is an overly conservative estimate, since all our expansion projects are targeting the low income populations in our service areas that are either on Medicaid, or are Medicaid-eligible.

Category 3 outcomes: (by DY 5)  
Our goals are to reduce the impact of cancer by increasing early detection screenings for cervical cancer (IT-12.2), breast cancer (IT-12.1), and colorectal cancer (IT-12.3).
Project Option 1.1.1 – Establish more primary care clinics: New North Harris County Healthcare Clinic

Unique RHP Project Identification Number: 111810101.1.9
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 1.1 Expand Primary Care Capacity (Option 1.1.1)

UT Physicians (UTP) intends to address the shortage of primary and specialty care in Region 3. In this project, UTP will establish the North Harris County Primary Care Clinic, which will provide primary care for the population in an area of Harris County that is between FM 1960 to the north, Cypress Creek Pkwy to the Northwest, Veteran’s Memorial Drive to the west, Aldine Mail Route to the south, and Highway 59N to the east. UTP has defined the service area for this clinic as a priority area for primary care services, because it is an area with a high rate of poverty. The population in this area is estimated to be 196,900 and is made up of 34 census tracts (CTs): 20 of the 34 fall within the top 25% of all census tracts in Harris County with the greatest number of people living below the federal poverty level (FPL), with 9 of those falling within the top 10%. (The CTs in the above defined service area that fall within the top 25% of Harris County CTs with the highest number of people living below the poverty line are: 5511, 5503.01, 5501, 2415, 2405.02, 2227, 2226, 2225.03, 2225.01, 5506.03, 5504.02, 5504.01, 5503.02, 5502, 5337.01, 5336, 2407.01, 2404, 2401, and 2230.02.) A total of 48,244 people in our defined service area are living below the FPL and a total of 99,482 are living below 185% of FPL. Furthermore, this area has a high rate of Hispanics (53.7%), for whom language, as well as poverty, may pose a barrier to obtaining primary care for their children. Black/African Americans, another segment of the population that tend to be medically underserved, also make up a significant proportion of the population (32.6%). Using the Harris County rate (14.5%) of Medicaid clients, there would be an estimated 28,551 Medicaid clients living within this service area. However, since this area has an exceptionally high rate of poverty, the number of Medicaid, or Medicaid-eligible clients, is expected to be much higher than this. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties. The Medicaid rate is from the U.S. Census Bureau and the Centers for Disease Control and Prevention, State and County by Demographic and Income Characteristics. SAHIE, 2009.)

The service area for this clinic includes large populations with economic, cultural, language, and transportation barriers to receiving primary care. In order to address the unique needs of this community in the north Harris County area, UTP has chosen to establish a primary care clinic in this area as an independent DSRIP project.

In order to implement this project, UTP will lease additional space to open the North Harris County Healthcare clinic. This space will include additional consulting, exam and procedure rooms. The clinic will offer expanded evening and weekend hours to improve access to low-wage workers, who often work in jobs that do not grant paid time off for illness, or healthcare related needs. UTP will recruit additional primary care providers and support staff to operationalize the project. UTP is uniquely positioned to attract and retain new physicians, because it is a part of the world-class academic and research institution, The University of Texas Health Science Center-Houston. Although the need in the defined service area for this project is so great that it could support many primary care clinics, there is currently only one community
health clinic that serves the indigent population (Harris Health’s Aldine Health Center) and it is on the southern-most border of our defined service area. Harris Health has not proposed any further clinics in this area, but UTP will collaborate with them to ensure that our clinic is placed optimally to provide the greatest convenience to the population without risking duplication of services provided by Harris Health. Furthermore, since this primary care clinic will provide services to the adult population, it will not duplicate services to be provided through Memorial Hermann Hospital’s proposed North Harris County Pediatric Clinic, but rather complement these services.

**Goal and Relationship to Regional Goals:**

**Project Goals:**

Expand primary care capacity to better accommodate the needs of the regional patient population and community, so that patients have enhanced access to the right health care services, at the right time, in the right setting.

This project addresses the following regional goals:

One of the goals of the region is to "Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay". Expansion of primary care capacity certainly relates to this goal as it will make it easier for UT Physicians to provide care to underserved populations.

**Challenges:**

- Need: 1) Inadequate access to primary care. 2) High rates of inappropriate emergency department utilization.
- Implementation: 1) Staff recruitment and retention. 2) Marketing of expansion.

By expanding the capacity of their clinics, UT Physicians will be better able to deliver timely care to more patients when needed thereby diverting patients away from the emergency room. UT Physicians will recruit physicians from the UTHealth residents placed at Memorial Hermann Hospital-TMC and will offer them a competitive salary and other incentives to practice in the outlying clinics. A marketing campaign that addresses the culture(s) and needs of the community will be implemented to inform the community of our expanded capacity to provide quality care that is convenient for them.

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

There will be shortening of waiting times for primary care appointments and increased uptake of primary care services in this service area, which will increase the percentage of patients who receive appropriate primary health care, including preventative services, regular screenings, and monitoring for those patients with chronic illnesses. UT Physicians expects to see an uptake of regular screenings particularly for breast cancer and colon cancer. Detecting cancer early can reduce the burden of the disease in terms of both improved health outcomes and lower costs. This project will benefit the Medicaid and low-income client base of this area, which is estimated to be a minimum of 28,551 (but likely to be much higher based on the demographics of the area). The expansion of service hours to nights and Saturdays will be of particular benefit to those unable to see a physician during business hours. The increase in primary care capacity, coupled with our transition to the team-based, proactive healthcare delivery model of medical homes, all conveniently located where there is great need, will help to address many of the barriers that the
low-income population typically encounter in getting the appropriate care, facilitating better health outcomes. By expanding primary capacity in this community, we expect to deliver a total of 48,936 patient visits by the end of DY5. At our current payer mix of 23% Medicaid, at least 11,255 of these would be Medicaid visits. However, this is a very conservative estimate, since all our expansion projects are targeting the low income populations in our service areas that are either on Medicaid, or are Medicaid-eligible.

Starting Point/Baseline:
UTHSC-H has identified the targeted service area needing increased access to primary care. Since this will be a new clinic, the baseline is 0. Targets for milestones and metrics are based upon the capacity of the clinic.

Rationale:
Research has shown that access to primary care is associated with better health outcomes at less cost. Access to primary care ensures better preventive care and better management of chronic disease, with lack of access often resulting in more expensive care, received in hospitals and emergency departments (ED). For the fiscal year 2010, 10% of all potentially preventable hospitalizations (PPR) were ambulatory care sensitive. In 2009, 41% (390,945) of ED visits in Houston were primary care related (PCR), including non-urgent, primary care treatable, and primary care preventable, and for 26.8% (104,762) of these PCR visits, Medicaid was the payor. Getting more patients into primary care will help to reduce the use of this more costly care. Placing more primary care providers out in the communities served by the UT Physicians will help to address transportation access barriers and the expansion of clinic service hours will provide a greater selection of available appointment times. By increasing primary care capacity and engaging more people in the primary care system, avoiding inappropriate utilization of costly services, the community will experience better health outcomes and greater patient satisfaction. (PPR rate was from the Texas Health and Human Services Commission report on Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal year 2010, published January, 2012. The statistics for ED use were from the Houston Hospitals Emergency Department Use Study (January 1, 2009 through December 31, 2009), Final Report, prepared by the UT School of Public Health, May 2011, included in the 2010 Harris County Community Needs Assessment for Memorial Hermann.)

Project Components:
Through the New North Harris County Healthcare Clinic, we propose to:
  a) Identify and lease appropriate space within the defined service area to establish a new clinic.
  b) Once leased, we will recruit primary care physicians and support staff.
  c) The clinic will operate with expanded evening and Saturday hours to increase access.

Milestones and Metrics:
For the Expand Existing Primary Care Capacity at UT Physicians Clinics Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.
Process Milestones and Metrics:

- **Milestone 1 [P-X]**: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign
  
  Metric 1 [P-X.1]: Documentation of plan for the new clinic.

- **Milestone 2 [P-X]**: Designate/hire personnel or teams to support and/or manage the project/intervention
  
  Metric 1 [P-X.2]: Project managers, personnel assigned to teams, and team responsibilities

- **Milestone 3 [P-X3]**: Conduct community outreach and marketing
  
  Metric 1 [P-X3.1]: Conduct community outreach and marketing

- **Milestone 4 [P-1]**: Establish an additional primary care clinic
  
  Metric 1 [P-1.1]: Number of additional clinics.

- **Milestone 5 [P-5]**: Hire additional primary care providers and staff
  
  Metric 1 [P-5.1]: Documentation of increased number of providers and staff.

- **Milestone 7 [P-5]**: Hire additional primary care providers and staff
  
  Metric 1 [P-5.1]: Documentation of increased number of providers and staff

- **Milestone 8 [P-4]**: Expand the hours of a primary care clinic, including evening and/or weekend hours
  
  Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline

Improvement Milestones and Metrics:

- **Milestone 6 [I-12]**: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.
  
  Metric 1 [I-12.1]: Documentation of increased number of visits (DY3). Demonstrate improvement over prior reporting period.

- **Milestone 9 [I-12]**: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.
  
  Metric 1 [I-12.1]: Documentation of increased number of visits (DY4). Demonstrate improvement over prior reporting period.

- **Milestone 10 [I-12]**: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.
  
  Metric 1 [I-12.1]: Documentation of increased number of visits (DY5). Demonstrate improvement over prior reporting period.

- **Milestone 11 [I-12]**: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services
  
  Metric 1 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period

- **Milestone 12 [I-11]**: Patient satisfaction with primary care services.
  
  Metric 1 [I-11.1]: Improved Patient satisfaction scores

Unique community need identification numbers the project addresses:

This project addresses community needs CN.1 (Inadequate access to primary care) and CN.8 (High rates of inappropriate emergency department utilization).

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
UT Physicians operates 4 clinics that serve areas that include large populations with economic, cultural, language, and transportation barriers to receiving primary care. This project proposes to add a new clinic in a different location where there is also a large population with economic, cultural, language, and transportation barriers to receiving primary care and where the demand for services is high. While this project is an expansion of UTP services in order to improve access to care, it is a new clinic in an area of great need.

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

**OD-12 Primary Care and Primary Prevention**
- IT-12.2 Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)
  Numerator: Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. Denominator: Women aged 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix are excluded.

**OD-12 Primary Care and Primary Prevention**
- IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)
  Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period. Denominator: Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded.

**OD-12 Primary Care and Primary Prevention**
- IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)
  Numerator: Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years
  Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.

**Relationship to other Projects:**
In addition to the UTP Pass-2 project for adding specialty services to this new primary care clinic in the North Harris County defined service area, in order to provide greater access to integrated care, this project is related to the below Pass 1 projects proposed by UT Physicians.

1.2 (A2, SPH1) - Increased training of primary care workforce will provide physicians and support staff needed to expand primary care capacity.
1.7 (A1) - Expanded primary care capacity will facilitate and enhance access to specialty care via telemedicine.
1.10 (MS1) - The systems engineering and user dashboards will give providers greater access to information and provide reports facilitating a continuous quality improvement process.
2.1 (C1-2) - As part of the medical home project, all patients will be assigned to a primary care provider within the UT Health medical home. Expanded primary care capacity will be a necessary step to making this possible.
2.2 (CL3, C5-C9) - Expanded capacity in primary care will ensure the availability of staff to implement the expansion of the chronic care management model for the targeted diseases.
2.11 (C10) - The medication management program will be an integral part of the coordinated care provided by the primary care physicians.
2.12 (A3, CL1, CL2, MS4) - For the various care transition projects to be successful, UT Health needs to ensure it has adequate primary care capacity to handle the increased volume of patients.

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

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

**Project Valuation:**
The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTP used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. **Transformational Impact** (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. **Population Served/Project Size** (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.

3. **Aligned with Community Needs** (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. **Cost Avoidance** (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects.
5. **Partnership/Collaboration** (Weight = 10%): *This was not rated*, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. **Sustainability** (Weight = 15%): *This was also not rated*, because UTHealth does not consider any of the projects to be unsustainable or at the very least do not consider one project less sustainable than another. Giving the projects the same or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
**Related Category 3 Outcome Measure(s):**
- Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)
- Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)
- Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 [P-X]:</strong> Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign</td>
<td><strong>Milestone 4 [P-1]:</strong> Establish an additional primary care clinic</td>
<td><strong>Milestone 7 [P-5]:</strong> Hire additional primary care providers and staff</td>
<td><strong>Milestone 10 [I-12]:</strong> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services</td>
</tr>
<tr>
<td>Metric 1 [P-X.1]: Documentation of plan for the new clinic. Baseline/Goal: Implementation plan (eligibility criteria, implementation components, responsibilities, and timeline). Data Source: UT Physicians' documents.</td>
<td>Metric 1 [P-1.1]: Number of additional clinics. Goal: 1 new clinic Data Source: New primary care schedule and other UT Physicians' documents.</td>
<td>Metric 1 [P-5.1]: Documentation of increased number of providers and staff. Baseline/Goal: Hire 1 FTE physicians; 1 FTE NP’s; 1 support staff Data Source: UT Physicians' report, policy, contract or other documentation</td>
<td>Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase of 898 patient visits over previous reporting period for a total of 19,116 patient visits for DY5 Data Source: Registry, EHR, claims or other UT Physicians’ source.</td>
</tr>
<tr>
<td>Milestone 1 Estimated incentive payment: $1,351,323</td>
<td>Milestone 4 Estimated incentive payment: $1,516,605</td>
<td>Milestone 7 Estimated incentive payment: $1,641,179</td>
<td>Milestone 10 Estimated incentive payment: $1,490,067</td>
</tr>
<tr>
<td><strong>Milestone 2 [P-X]:</strong> Designate/hire personnel or teams to support and/or manage the project/intervention</td>
<td><strong>Milestone 5 [P-5]:</strong> Hire additional primary care providers and staff</td>
<td><strong>Milestone 8 [P-4]:</strong> Expand the hours of a primary care clinic, including evening and/or weekend hours</td>
<td><strong>Milestone 11 [I-12]:</strong> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services</td>
</tr>
<tr>
<td>Metric 1 [P-X.2]: Project managers, personnel assigned to teams, and team responsibilities Baseline/Goal: 1 Project Manager; 3 support personnel; Data Source: Program Documentation</td>
<td>Metric 1 [P-5.1]: Documentation of increased number of providers and staff. Baseline/Goal: Hire 2 FTE physicians; 2 FTE NP’s; 2 nurses; 4 support staff Data Source: HR documents, UT Physicians' report, policy, contract or other documentation</td>
<td>Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline Baseline/Goal: Add 4 hours Saturday and 2 evening clinics (6hrs) Data Source: Clinic documentation</td>
<td>Metric 1 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. Goal: Increase by 10% the number of unique patients Data Source: Registry, EHR, claims</td>
</tr>
<tr>
<td>Milestone 2 Estimated incentive</td>
<td>Milestone 5 Estimated incentive payment: $1,516,605</td>
<td>Milestone 8 Estimated incentive payment: $1,641,179</td>
<td>Milestone 11 Estimated incentive payment: $1,641,179</td>
</tr>
<tr>
<td><strong>Milestone 3 [P-1]:</strong> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services</td>
<td><strong>Milestone 6 [I-12]:</strong> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services</td>
<td><strong>Milestone 9 [I-12]:</strong> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services</td>
<td><strong>Milestone 12 [I-12]:</strong> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services</td>
</tr>
<tr>
<td>Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase of 898 patient visits over previous reporting period for a total of 19,116 patient visits for DY5 Data Source: Registry, EHR, claims or other UT Physicians’ source.</td>
<td>Metric 1 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. Goal: Increase by 10% the number of unique patients Data Source: Registry, EHR, claims</td>
<td>Metric 1 [I-12.3]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. Goal: Increase by 10% the number of unique patients Data Source: Registry, EHR, claims</td>
<td>Metric 1 [I-12.4]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. Goal: Increase by 10% the number of unique patients Data Source: Registry, EHR, claims</td>
</tr>
<tr>
<td>Milestone 3 Estimated incentive</td>
<td>Milestone 6 Estimated incentive</td>
<td>Milestone 9 Estimated incentive</td>
<td>Milestone 12 Estimated incentive</td>
</tr>
<tr>
<td>111810101.1.9</td>
<td><strong>OPTION 1.1.1</strong></td>
<td><strong>A-C</strong></td>
<td>NEW NORTH HARRIS COUNTY HEALTHCARE CLINIC</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
<td>--------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td></td>
<td>UTHealth, UTPhysicians</td>
<td></td>
<td>111810101</td>
</tr>
</tbody>
</table>

**Related Category 3 Outcome Measure(s):**
- IT-12.2
- IT-12.1
- IT-12.3
- Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)
- Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)
- Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 3** [P-X3]: Conduct community outreach and marketing

**Metric 1** [P-X3.1]: Conduct community outreach and marketing

Goal: Reach all households in targeted service areas with a bi-lingual mailer announcing services to be provided at the new clinic  
Data Source: Mailing list, mailing contract, mailer

Milestone 3 Estimated incentive payment: $1,351,323

evidence of improved access for patients seeking services.

Metric 1 [I-12.1]: Documentation of increased number of visits.  
Demonstrate improvement over prior reporting period.  
Baseline: 0  
Goal: Increase of 11,602 patient visits over baseline, and total for DY3.  
Data Source: Registry, EHR, claims or other UT Physicians’ source

Milestone 6 Estimated incentive payment: $1,516,604

care clinic volume of visits and evidence of improved access for patients seeking services.

Metric 1 [I-12.1]: Documentation of increased number of visits.  
Demonstrate improvement over prior reporting period.  
Goal: Increase of 6,616 patient visits over DY3, for a total of 18,218 patient visits for DY4.  
Data Source: Registry, EHR, claims or other UT Physicians’ source

Milestone 9 Estimated incentive payment: $1,641,179

or other UT Physicians’ source.

Milestone 11 Estimated incentive payment: $1,490,067

**Milestone 12** [I-11]: Patient satisfaction with primary care services.

Metric 1 [I-11.1]: Improved Patient satisfaction scores  
Baseline: Overall Mean Score is 87.6; Ability to get appointment when wanted is 82.7  
Goal: A statistically significant increase at the 95% confidence level in both the overall mean score for patient satisfaction and in the score for ability to get appointment when wanted.  
Data Source: CG-CAHPS3 or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population.

Milestone 12 Estimated incentive payment: $1,490,067

Year 2 Estimated Milestone Bundle Amount: $4,053,969  
Year 3 Estimated Milestone Bundle Amount: $4,549,814  
Year 4 Estimated Milestone Bundle Amount: $4,923,537  
Year 5 Estimated Milestone Bundle Amount: $4,740,201
<table>
<thead>
<tr>
<th>111810101.1.9</th>
<th>OPTION 1.1.1</th>
<th>A-C</th>
<th>NEW NORTH HARRIS COUNTY HEALTHCARE CLINIC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UTHealth, UTPhysicians</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Related Category 3 Outcome Measure(s):
- 111810101.3.29: IT-12.2
- 111810101.3.30: IT-12.1
- 111810101.3.31: IT-12.3
- Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)
- Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)
- Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $18,267,521
Project Option 1.9.2 – Expand Specialty Care Capacity: Expand UT Physician Specialty Services to North Harris County

Unique RHP Project Identification Number: 111810101.1.10
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians (UTP) is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
UT Physicians will recruit specialists for the new primary care clinic in North Harris County. This will further enable expansion of UT Health specialty services to another area outside the Texas Medical Center. The new primary care clinic’s service hours will be extended to provide evening and weekend appointment options, which will be covered by the UTP specialty services as well. Standardized referral systems will be put in place to ensure access to these specialists.

Need for the project:
This project addresses the county’s inadequate access specialty care, especially for the service area for this clinic which includes large populations with economic, cultural, language, and transportation barriers to receiving healthcare. In order to address the unique needs of this community in Harris County, there is need to extend specialty care services to this area.

Target Population:
The target population are those living in an area of Harris County that is between FM 1960 to the north, Cypress Creek Pkwy to the Northwest, Veteran’s Memorial Drive to the west, Aldine Mail Route to the south, and Highway 59N to the east. The population in this area is estimated to be 196,900, out of which 48,244 persons are living below the federal poverty level.

Category 1 or 2 expected patient benefits:
Our goal is to increase the number of specialist providers, clinic hours and/or procedure hours available to this community for the high impact/most impacted medical specialties, and to increase the number of referrals of targeted patients to the specialty care clinic. We expect to complete over 16,000 patient visits by DY5, with greater than 3,800 of these being to Medicaid, or Medicaid-eligible, patients. This is a very conservative estimate, since there are over 99,000 people in this service area living within 185% of the federal poverty level.


**Category 3 outcomes:**
The goal will be to increase the percentage of patients who had each of the following during the reporting period: Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year), and LDL-C Level <100 mg/dL (IT-1.6).
Project Option 1.9.2 – Expand Specialty Care Capacity: Expand UT Physician Specialty Services to New North Harris County Primary Care Clinic

Unique RHP Project Identification Number: 111810101.1.10
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 1.9 Expand Specialty Care Capacity (Option 1.9.2)

UT Physicians will recruit specialist(s) for the new primary care clinic in North Harris County, based upon the specialty care gap assessment to be conducted for this service area. This will further enable expansion of UT Health specialties in another area outside the Texas Medical Center where there is great need. This will enable expansion of UT Health specialties in areas outside the Texas Medical Center and into another area where economic and transportation barriers exist and where there is a great need for ambulatory care (see below description of UTP service areas targeted by this project). At a minimum of 2 FTE specialists, this expansion would enable approximately 7,600 patient visits per year. The new primary care clinic’s service hours will be extended to provide evening and weekend appointment options, which will be covered by the UTP specialty services as well. Standardized referral systems will be put in place to ensure access to these specialists.

Additionally, where there is a need for multiple specialties on a more limited basis, we will provide access to the UT Health Regional Multispecialty Physician Group via telemedicine. We plan to develop a rapid e-mail and/or internet based/technologically driven consultation process to manage complicated diabetes and other patients of the primary care community clinics who would otherwise require a referral to specialists in the Texas Medical Center. We will recruit specialists, physician assistants and nurse practitioners to manage the process.

Also, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project to ensure that we are delivering the right care to those in need, where it is needed. We will also use these QI processes to identify challenges for further expansion and to build on lessons learned.

UTP will market the availability of specialty services to those within the defined service area for the new clinic, which includes an area of Harris County that is between FM 1960 to the north, Cypress Creek Pkwy to the Northwest, Veteran’s Memorial Drive to the west, Aldine Mail Route to the south, and Highway 59N to the east. UTP has defined the service area for this clinic as a priority area for primary care services, because it is an area with a high rate of poverty. The population in this area is estimated to be 196,900 and is made up of 34 census tracts (CTs): 20 of the 34 fall within the top 25% of all census tracts in Harris County with the greatest number of people living below the federal poverty level (FPL), with 9 of those falling within the top 10%. (The CTs in the above defined service area that fall within the top 25% of Harris County CTs with the highest number of people living below the poverty line are: 5511, 5503.01, 5501, 2415, 2405.02, 2227, 2226, 2225.03, 2225.01, 5506.03, 5504.02, 5504.01, 5503.02, 5502, 5337.01, 5336, 2407.01, 2404, 2401, and 2230.02.) A total of 48,244 people in our defined service area are living below the FPL and a total of 99,482 are living below 185% of FPL. Furthermore, this area has a high rate of Hispanics (53.7%), for whom language, as well as poverty, may pose a barrier to obtaining primary care for their children. Black/African Americans, another segment of
the population that tend to be medically underserved, also make up a significant proportion of the population (32.6%). Using the Harris County rate (14.5%) of Medicaid clients, there would be an estimated 28,551 Medicaid clients living within this service area. However, since this area has an exceptionally high rate of poverty, the number of Medicaid, or Medicaid-eligible clients, is expected to be much higher than this. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties. The Medicaid rate is from the U.S. Census Bureau and the Centers for Disease Control and Prevention, State and County by Demographic and Income Characteristics. SAHIE, 2009.) The service area for this clinic includes large populations with economic, cultural, language, and transportation barriers to receiving healthcare. In order to address the unique needs of this community in Harris County, UTP has chosen to extend specialty care services to this area.

Goal and Relationship to Regional Goals:

Project Goal:
To increase the capacity to provide specialty care services and the availability of targeted specialty providers to better accommodate the high demand for specialty care services so that patients have increased access to specialty services.

This project addresses the following regional goal:
The region aims to "Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay." By expanding specialty care services, patients will have greater access to specialty care when needed.

Challenges:
Need: 1) Inadequate access to specialty care. 2) Insufficient access to care coordination and integrated care treatment programs.
Implementation: 1) Staff recruitment and retention. 2) Coordination of specialty care and primary care appointments.

As the physician practice arm of the world-class academic and research institution, University of Texas Health Science Center-Houston, UTP is uniquely positioned to attract and retain new physicians. All providers and staff will be trained and a quality improvement process will be put in place to ensure that we achieve optimum coordination of services. Increased availability of specialty care services in these outlying clinics will improve access to specialty care and make it possible for patients to receive care in an integrated manner.

5-Year Expected Outcome for Provider and Patients:
There will be shortening of waiting times for specialty care appointments, such as for cardiology care, and better disease management for those with targeted chronic diseases. This project will benefit the Medicaid and low-income client base of this area, which is estimated to be a minimum of 28,551 (but likely to be much higher based on the demographics of the area). The expansion of service hours to nights and Saturdays will be of particular benefit to those unable to see a physician during business hours. The increase in specialty care capacity, coupled with our transition to the team-based, proactive healthcare delivery model of medical homes, all conveniently located where there is great need, will help to address many of the barriers that the low-income population typically encounter in getting the appropriate care, facilitating better
health outcomes. While positive outcomes are expected for each area of specialty care offered, we will specifically be monitoring the increased access to cardiology care for patients at risk of, or with heart disease. It is expected that increased access to cardiology care for these patients will result in increased cholesterol screening and lower LDL-C rates.

By increasing specialty services to this high need area, we expect to complete over 16,000 patient visits by DY5, with greater than 3,800 of these being to Medicaid, or Medicaid-eligible, patients. This is a very conservative estimate, since there are over 99,000 people in this service area living within 185% of the federal poverty level. These numbers only reflect the minimum 1 FTE specialists and not the additional patient visits that would occur via the telemedicine option, where needed.

**Starting Point/Baseline:**
Since these will be new specialty services being provided at a new primary care clinic opening in North Harris County, the baseline is zero. Targets are set based upon the capacity planned for this clinic.

**Rationale:**
Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems, and our region has problems of access to specialty care as reflected in the regional community needs assessment. To achieve success as an integrated network, this gap must be thoroughly addressed by expanding specialty care services to underserved populations. The availability of specialists to provide care in this area will allow patients to access care where and when needed, thereby potentially reducing the need for emergency care, complications, and hence improve the overall health and wellbeing of the community.

**Project Components:**
Through the Expand UT Physician Specialty Services to North Harris County project, we propose to meet all required project components listed below:

a) UTP will conduct a specialty care gap assessment for the North Harris County service area.

b) UTP will recruit specialists of the type identified in the gap assessment to provide specialty services in this area.

c) Space will be identified and secured at the primary care clinic and additional support staff recruited to support the provision of specialty care.

d) UTP will provide specialty services in the North Harris County primary care clinic, which will include extended evening and Saturday hours.

e) UTP will implement transparent, standardized referrals across the system.

f) UTP will use a new telemedicine program to provide specialty services where the demand may not justify full FTE specialists.

g) UTP’s quality improvement office will conduct QI for the clinic providing specialty care using methods such as rapid cycle improvement.

**Milestones and Metrics:**
For the Expand UT Physician Specialty Services to North Harris County project, we have chosen the below milestones and metrics based upon the above project components and
relationship to project goals and population needs. All baselines and goals will be determined during DY2.

**Process Milestones and Metrics:**

**Milestone 1** [P-1.]: Conduct specialty care gap assessment based on community need
Metric 1 [P-1.1.]: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2).

**Milestone 2** [P-3.]: Collect baseline data for wait times, backlog, and/or return appointments in specialties
Metric 1 [P-3.1.]: Establish baseline for performance indicators

**Milestone 3** [P-6.]: Develop and implement standardized referral and work-up guidelines
Metric 1 [P-6.1.]: Referral and work-up guidelines

**Milestone 4** [P-11.]: Launch/expand a specialty care clinic
Metric 1 [P-11.1]: Establish/expand specialty care clinics

**Milestone 5** [P-5.]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment
Metric 1 [P-5.1.]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians)

**Milestone 6** [P-5.]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment
Metric 1 [P-5.1.]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians)

**Milestone 7** [P-21.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.
Metric 1 [P-21.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Milestone 8** [I-23.]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.
Metric 1 [I-23.1.]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2)

**Milestone 9** [P-5.]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment
Metric 1 [P-5.1.]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians)

**Milestone 10** [P-21.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.
Metric 1 [P-21.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Improvement Milestones and Metrics:**

**Milestone 8** [I-22.]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties
Metric 1 [I-22.1.]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties

**Milestone 12** [I-23.]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services.
Metric 1[I-23.1.]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (DY4).

Unique community need identification numbers the project addresses:
This project addresses community needs CN.2 (Inadequate access to specialty care) and CN.7 (Insufficient access to care coordination practice management and integrated care treatment programs).

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Providing specialty care in a new clinic in the defined service area and outside the Texas Medical Center is a new initiative that will increase access to specialty care where and when needed. This is a service that is needed in the north Harris County service area, which will serve a large population with economic, cultural, language, and transportation barriers to receiving care.

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management
- IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure)
  Increase the number of patients who had each of the following during the reporting period:
  Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed during the measurement year.
  LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL.

Relationship to other Projects:
In addition to the UTP Pass-2 project for adding a new primary care clinic in the North Harris County defined service area, for which this project is intended to enhance access to integrated care, this project is related to the below Pass 1 projects proposed by UT Physicians.
2.2 (C5-9,CL3) - This project will ensure that chronic care patients get specialist input into their care when needed, without the current delays being experienced.
2.11 (C10) - The medication management project will serve as a useful resource to every provider involved in managing the enrolled patients, to ensure optimum outcomes.
2.12 (A3, CL1, CL2, MS4) - The expansion of specialty care into the primary care settings will complement the care transition projects to ensure that patients get the right care at the right time.

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

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

**Project Valuation:**
The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTP used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. **Transformational Impact** (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. **Population Served/Project Size** (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.

3. **Aligned with Community Needs** (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. **Cost Avoidance** (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects.

5. **Partnership/Collaboration** (Weight = 10%): **This was not rated**, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. **Sustainability** (Weight = 15%): **This was also not rated**, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1** [P-1.]: Conduct specialty care gap assessment based on community need

Metric 1 [P-1.1.]: Documentation of gap assessment. Goal: Gap assessment will show what specialties need to be recruited in the area.
Data Source: Needs Assessment
Milestone 1 Estimated incentive payment: $841,808

**Milestone 2** [P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties

Metric 1 [P-2.1]: Training of staff and providers on referral guidelines, process and technology
Milestone 2 Estimated incentive payment: $841,808

**Milestone 3** [P-6]: Develop and implement standardized referral and work-up guidelines

**Milestone 4** [P-11]: Launch/expand a specialty care clinic
Metric 1 [P-11.1]: Establish/expand specialty care clinics. Baseline/Goal: Hire 1 FTE physician and 1 support staff. Data Source: Documentation of new/expanding specialty care clinic
Milestone 4 Estimated incentive payment: $1,417,155

**Milestone 5** [P-5]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment
Metric 1 [P-5.1]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians). Goal: Keep wait times to next clinic day from completion of referral; referral process completed within 48 hours 90% of the time. Data Source: EHR, Referral Management system, Administrative records. (Generated Reports on file)
Milestone 5 Estimated incentive payment: $766,781

**Milestone 6** [P-5.1]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment
Metric 1 [P-5.1.1]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians). Goal: Keep wait times to next clinic day from completion of referral; referral process completed within 48 hours 95% of the time. Data Source: EHR, Referral Management system, Administrative records. (Generated Reports on file)
Milestone 6 Estimated incentive payment: $984,304

**Milestone 7** [P-21.1]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.
Metric 1 [P-21.1.1]: Participate in semi-annual face-to-face meetings or

**Milestone 10** [P-5.1]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment
Metric 1 [P-5.1.1]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians). Goal: Keep wait times to next clinic day from completion of referral; referral process completed within 48 hours 90% of the time. Data Source: EHR, Referral Management system, Administrative records. (Generated Reports on file)
Milestone 10 Estimated incentive payment: $984,304

**Milestone 11** [P-21.1]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.
Metric 1 [P-21.1.1]: Participate in semi-annual face-to-face meetings or
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>111810101.3.32</th>
<th>IT-1.6</th>
<th>Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Metric 1 [P-6.1.]:** Referral and work-up guidelines
Goal: Update, create and train staff on policies and procedures
Data Source: Referral and work-up policies and procedures documents

<table>
<thead>
<tr>
<th>Milestone 3 Estimated incentive payment: $ 841,807</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Metric 1 [I-22.1.]:** Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties
Baseline/Goal: Hire 1 FTE physician and 1 support staff
Data Source: HR documents or other documentation demonstrating employed/contracted specialists

<table>
<thead>
<tr>
<th>Milestone 8 Estimated incentive payment: $766,780</th>
</tr>
</thead>
</table>

Milestones 8

**Milestone 8 [I-22]:** Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties

<table>
<thead>
<tr>
<th>Milestone 7 Estimated incentive payment: $766,781</th>
</tr>
</thead>
</table>

Milestones 7

**Milestone 9 [I-23.]:** Increase

<table>
<thead>
<tr>
<th>Milestone 8 Estimated incentive payment: $766,781</th>
</tr>
</thead>
</table>

Milestones 8

**Milestone 10 [I-23.]:** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services

<table>
<thead>
<tr>
<th>Milestone 11 Estimated incentive payment: $ 984,304</th>
</tr>
</thead>
</table>

Milestones 11

**Milestone 12 [I-23.]:** Documentation of increased number of visits.
Demonstrate improvement over prior reporting period.
Goal: Increase patients visits by 772 over prior reporting period, for a total of 7,031 patients visits for DY5.
Data Source: Registry, EHR, claims or other Performing Provider source

<table>
<thead>
<tr>
<th>Milestone 12 Estimated incentive payment: $ 984,304</th>
</tr>
</thead>
</table>

Milestones 12

**Milestone 13 [I-23.1.]:** Documentation of increased number of visits.
Demonstrate improvement over prior reporting period.
Goal: Increase patients visits by 772 over prior reporting period, for a total of 7,031 patients visits for DY5.
Data Source: Registry, EHR, claims or other Performing Provider source

<table>
<thead>
<tr>
<th>Milestone 13 Estimated incentive payment: $ 984,304</th>
</tr>
</thead>
</table>

Milestones 13
<table>
<thead>
<tr>
<th>111810101.1.10</th>
<th>1.9.2</th>
<th>A-D</th>
<th>EXPAND UT PHYSICIAN SPECIALTY SERVICES TO NORTH HARRIS COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTHealth, UTPhysicians</td>
<td>111810101</td>
<td>1.10</td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td><strong>111810101.3.32</strong></td>
<td><strong>IT-1.6</strong></td>
<td>Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure)</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
<tr>
<td>specialty care clinic volume of visits and evidence of improved access for patients seeking services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 [I-23.1.]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). Baseline: 0 (new clinic) Goal: Increase by 6,259 patient visits over baseline. Data Source: Registry, EHR, claims or other Performing Provider source</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 9 Estimated incentive payment: $ 766,780</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $2,525,423</td>
<td>Year 3 Estimated Milestone Bundle Amount: $2,834,310</td>
<td>Year 4 Estimated Milestone Bundle Amount: $3,067,121</td>
<td>Year 5 Estimated Milestone Bundle Amount: $2,952,912</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $11,379,767</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Tomball Regional Hospital
Pass 1
Project Option 1.1.2- Expand existing primary care capacity: Expand primary care access for uninsured populations within and around Tomball

**Unique RHP Project ID:** 288523801.1.1.1  
**Performing Provider Name/TPI:** Tomball Regional Medical Center / 288523801

**Project Summary:**
Tomball Regional Medical Center is a 358 bed acute care hospital located in Northwest Harris County. The hospital is a private for-profit facility that has provided $39.3m in uncompensated care for 2012 and $1.8m charity care.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions- 10,004</td>
<td>Self-Pay- 9%</td>
<td>Hispanic- 13%</td>
</tr>
<tr>
<td>Births (babies delivered)- 709</td>
<td>Medicaid and CHIP- 15%</td>
<td>African American- 30%</td>
</tr>
<tr>
<td>Emergency visits- 32,935</td>
<td>Medicare- 34%</td>
<td>Caucasian- 50%</td>
</tr>
<tr>
<td>Outpatient clinic visits- 78,088</td>
<td>Other Funding- 1%</td>
<td>Asian- 4%</td>
</tr>
<tr>
<td></td>
<td>Commercial Insurance- 41%</td>
<td>Other- 1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>American Indian- 2%</td>
</tr>
</tbody>
</table>

**Intervention(s):**
This project will expand access to primary care for the uninsured by the hospital providing nurse practitioner and office resources to the local indigent care clinic. This resource will allow the clinic to expand hours of coverage into the evenings.

**Need for the project:**
The purpose of this project is to provide treatment to the working uninsured for medical conditions that if managed timely will prevent the conditions from escalating to the point of needing treatment in a hospital setting. In 2012, the hospital treated 8,340 uninsured patients in the emergency setting.

**Target Population:**
The target population will be the 8,340 uninsured emergency room patient and the estimated 10,000 citizens in the local market without medical coverage.

- **Category 1 or 2 expected patient benefits:** The project seeks to increase primary care clinic visits in DY4 by 1,300 and 1,339 in DY5.
- **Category 3 outcomes:** IT-2.5 Tomball Regional Medical Center goal is to reduce the COPD admission rates from 267, by 6 in DY 3, 12 in DY 4 and 15 in DY 5.
- **Category 3 outcomes:** IT-2.10 Tomball Regional Medical Center goal is to reduce flu and pneumonia admissions from 594 in 2012 by 12 in DY 3, 24 in DY 4 and 30 in DY 5.
- **Category 3 outcomes:** IT-3.1 Tomball Regional Medical Center goal is to reduce the 30-day potentially preventable all-cause readmission rate from 13% currently to 10% by DY5.
- **Category 3 outcomes:** IT-9.2 Tomball Regional Medical Center goal is to reduce the ED utilization for the lower level acuity visits by 48 DY3, 96 DY4 and 120 DY5.
Project Option 1.1.2 – Expand existing primary care capacity: Expand primary care access for uninsured populations within and around Tomball.

**Unique RHP Project Identification Number:** 288523801.1.1  
**Performing Provider Name/TPI:** Tomball Regional Medical Center / 288523801

**Project Description:**
Tomball Regional Medical Center (TRMC), the area’s full service hospital, is proposing a Category 1 DSRIP project to expand primary care access for the uninsured population within and around The City of Tomball.

This project will allow patients to receive the right care at the right time in the right setting. The project will be a partnership of Tomball Hospital Authority (IGT partner), TOMAGWA Healthcare Ministries, a comprehensive family practice clinic, and Tomball Regional Hospital.

TRMC is proposing to provide the professional services of a mid-level provider and office staff to TOMAGWA, so that they may expand their services by providing expanded hours of clinic operations in their current location. TOMAGWA would provide the facilities. Additional facilities are not needed at this time as the clinic space is not used after 5:00pm. This mid-level provider would need to be supervised by a current licensed physician on the staff of TOMAGWA.

TOMAGWA would operate the clinic under its current reduced fee schedules and charity/indigent guidelines. This would improve access to care for the working uninsured that cannot afford to take off during business hours and pay normal physician office rates. We are currently proposing that the expanded hours of operations for this clinic would be from 5:00pm until 9:00pm Monday through Friday. Payment for each office visit would be based on the current TOMAGWA fee schedule and charity care guidelines.

**Project Goals:**
Expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting.

- Expanded hours to see a targeted 10 patients per day
- Reduce preventable admissions by 4%
- Reduce readmissions by 4%
- Reduce overuse of the emergency room 5%

**Starting Point/Baseline:**
The clinic does not currently have after-hours operations. The baseline for the clinic visits would be zero. However, the hospital does see these patients via the emergency room and in the inpatient setting. The top acute care hospital admissions DRG’s (excluding births) for Tomball Regional Medical Center for the eight months ending August 31, 2012 for Medicaid and uninsured patients are:
<table>
<thead>
<tr>
<th>DRG</th>
<th>Number of Cases</th>
<th>Hospital Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cellulitis w/o cc/mcc</td>
<td>37</td>
<td>$967,678</td>
</tr>
<tr>
<td>Esophagitis, Gastrent $ misc Digest disorders w/o MCC</td>
<td>28</td>
<td>$610,525</td>
</tr>
<tr>
<td>Simple pneumonia &amp; pleurisy w mcc</td>
<td>15</td>
<td>$551,345</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease w MCC</td>
<td>14</td>
<td>$455,147</td>
</tr>
</tbody>
</table>

These admissions are identified as conditions that with proper treatment and patient educations may either be prevented or the severity can be reduced. By improving access to primary care providers these patients can receive the outpatient treatment and care plans that they have not been receiving or have been depending on the hospital emergency room to provide.

**Rationale:**
In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This situation often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will utilize the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

**Project Components:**
- Expand primary care clinic space
- Expand primary care clinic hours
- Expand primary care clinic staffing

**Unique community need identification number the project addresses:**
- CN.1 Inadequate access to primary care
- CN.2 Inadequate access to specialty care
- CN.6 Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly
- CN.7 Insufficient access to care coordination practice management and integrated care treatment programs
- CN.8 High rates of inappropriate emergency department utilization
- CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including: Cancer, Diabetes, Obesity, Cardiovascular disease, Asthma, AIDS/HIV

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This project proposes to add one practioneer and extend the hours of operation of the indigent care clinic. By increasing these available resources we will meet the following community needs.
Related Category 3 Outcome Measure(s):
- IT-2.5 Reduce admissions COPD
- IT-2.10 Flu and pneumonia Admissions rates
- IT-3.1 Potentially preventable re-admissions 30 day
- IT -9.2 ED appropriate utilization

- Category 1 or 2 expected patient benefits: The project seeks to increase primary care clinic visits in DY4 by 1,300 and 1,339 in DY5.
- Category 3 outcomes: IT-2.5 Our goal is to reduce the COPD admission rates from 267, by 6 in DY 3, 12 in DY 4 and 15 in DY 5
- Category 3 outcomes: IT-2.10 Our goal is to reduce flu and pneumonia admissions from 594 in 2012 by 12 in DY 3, 24 in DY 4 and 30 in DY 5.
- Category 3 outcomes: IT-3.1 Our goal is to reduce the 30-day potentially preventable all-cause readmission rate from 13% currently to 10% by DY5
- Category 3 outcomes: IT-9.2 Our goal is to reduce the ED utilization for the lower level acuity visits by 48 DY3, 96 DY4 and 120 DY5.

Reasons/Rationale for selecting the outcome measures:
By making services and education available to the low income population, patient will be able to identify mild illnesses and receive treatment prior to the conditions requiring emergency services. This will shorten the recovery time and therefore improve the overall health of the patient population.

Relationship to other performing providers’ projects in RHP:
Healthcare treatment cannot focus to only the acute or chronic encounter and properly treat the patient. It is critical that our region focuses to patient education and community education to ensure a proactive and responsive approach to healthcare needs. The education models represented in the Region 3 RHP plan can be identified in the Initiative Grid (addendum) and all focus to outcome measures such as appropriate utilization, patient satisfaction scores, and standalone chronic condition scores such as diabetes and asthma.

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

Project Valuation:
The value of the project is based on two parts:
1. Cost of expanding capacity via the staffing of the clinic with mid-level provider and support staff as detailed in the Category 1 table. With over 8,300 area population at or below the poverty guidelines, this supports the need for 3-4 primary care providers.
2. Payment reductions and reduced uncompensated care for reduced admissions, readmissions and ED visits.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>288523801.1.1</th>
<th>288523801.1.2</th>
<th>288523801.1.3</th>
<th>288523801.1.4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>288523801.3.1</strong></td>
<td><strong>IT 2.5</strong></td>
<td>Tomball Regional Medical Center</td>
<td><strong>IT-2.10</strong></td>
<td><strong>IT -3.1</strong></td>
<td><strong>IT -9.2</strong></td>
</tr>
<tr>
<td><strong>288523801.3.2</strong></td>
<td><strong>COPD Admission Rate</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>288523801.3.3</strong></td>
<td><strong>Flu and Pneumonia Admission rates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>288523801.3.4</strong></td>
<td><strong>Potentially preventable re-admission within 30 days</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</th>
<th><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</th>
<th><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</th>
<th><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P-5. Milestone:</strong> Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers</td>
<td><strong>P-4. Milestone:</strong> Expand the hours of a primary care clinic, including evening and/or weekend hours</td>
<td><strong>I-12. Milestone:</strong> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services to a total of 1950.</td>
<td><strong>I-12. Milestone:</strong> Increase primary care clinic volume of visits and evidence of improved access for patients seeking services to a total of 2600.</td>
</tr>
<tr>
<td><strong>P-5.1. Metric:</strong> Documentation of increased number of providers and staff and/or clinic sites. Goal: 1 new provider</td>
<td><strong>P-4.1. Metric:</strong> Increased number of hours at primary care clinic over baseline Goal: 1,040 additional hours</td>
<td><strong>I-12.1. Metric:</strong> Documentation of increased number of visits. Demonstrate improvement over prior reporting period Goal: 1300 visits</td>
<td><strong>I-12.1. Metric:</strong> Documentation of increased number of visits. Demonstrate improvement over prior reporting period Goal: 1339 visits</td>
</tr>
<tr>
<td>Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report.</td>
<td>Data Source: Clinic documentation.</td>
<td>Data Source: Registry, EHR, claims or other Performing Provider source</td>
<td>Data Source: Registry, EHR, claims or other Performing Provider source</td>
</tr>
<tr>
<td>Milestone Estimated Incentive Payment: $220,928</td>
<td></td>
<td>Milestone Estimated Incentive Payment: $227,472</td>
<td>Milestone Estimated Incentive Payment: $234,211</td>
</tr>
</tbody>
</table>

| **Year 2 Estimated Milestone Bundle Amount:** $214,572 | **Year 3 Estimated Milestone Bundle Amount:** $220,928 | **Year 4 Estimated Milestone Bundle Amount:** $227,472 | **Year 5 Estimated Milestone Bundle Amount:** $234,211 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $897,183
Category II
Project Option 2.1.1- Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards: The Fifth Ward Model – Inter-professional Primary Care

Unique RHP Project ID: 082006001.2.1
Performing Provider Name/TPI: Baylor College of Medicine/082006001

Summary:
Provider: Baylor Family and Community Medicine partners with multiple community-based healthcare organizations in the Harris County region to provide high quality, evidence-based care to underserved areas.
Intervention: This project will provide high quality, accessible, low-cost primary healthcare for Medicaid and under- or uninsured patients.
Need for the Project: This clinic will serve patients in the Greater Fifth Ward area of Houston, which has been indentified by the U.S. Department of Health and Human Services as a medically underserved area.
Target Population: Medicaid, under- and uninsured patients who do not currently have a medical home.
Category 2 Expected Benefits:
- The clinic will provide medical homes for up to 5,000 patients by DY5.
- Patients will receive comprehensive, coordinated services by an interprofessional team of practitioners.
- Patients will receive high quality care founded on evidence-based guidelines. Specific areas of clinical focus such as family planning, prenatal care or adolescent health care will be developed to meet the specific needs of the population.

Category 3 Outcomes:
- IT-1.10: Improve HbA1c control by 15% over baseline by DY5.
- IT-1.20: Improve weight management by 10% over baseline by DY5.
- IT-12.2: Improve cervical cancer screening by 10% over baseline by DY5.

Project Description:
The Fifth Ward Model Inter-Professional Primary Care Practice Demonstration Project will bring together an interdisciplinary team of healthcare professionals including physicians, mid-level providers (nurse practitioners and physicians’ assistants), nurses (RNs, LVNs), nursing assistants, clinical pharmacists (PharmDs), social workers, health educators, and mental health professionals (psychologists, licensed professional counselors) to provide interdisciplinary primary healthcare to patients residing in a medically underserved community of Houston (the 5th ward).

The practice will be located at the Pleasant Hill Baptist Church Center for Spiritual Growth, Health and Wellness, a facility focused on holistic health being developed in partnership with the 5th Ward Re-development Corporation; the Rice University Kinder Institute and Urban Health Program; the Duke Divinity School; YES Prep, an urban educational specialist; Can Do Houston, an urban food specialist; and the Baylor College of Medicine Department of Family and Community Medicine.

The primary care practice will be developed as a high performing Patient Centered Medical Home (PCMH), providing broad spectrum primary health care services including health
promotion and disease prevention, care of acute illnesses and injuries, care of common chronic diseases, care of common mental health problems, well woman, prenatal and gynecological services, care of infants and children, geriatric care, rehabilitative and palliative care through a multidisciplinary primary care team, with each team member practicing at the “top” of his or her training and professional license. The practice will be certified as a level 3 Patient Centered Medical Home, use a modern electronic medical record with a secure patient internet portal, and provide high quality care based on the most current evidence-based clinical practice guidelines, continuously measuring and striving to improve its processes and care outcomes.

The practice will serve as a demonstration project and laboratory for training healthcare professional students to work in inter-professional teams, involving faculty and students from Baylor College of Medicine, Prairie View A&M University School of Nursing, the University of Houston School of Pharmacy, Department of Psychology and School of Social Work, the University of Texas School of Public Health, etc.

**Goal(s) and Relationship to Regional Goal(s):**
The goal of this project is to provide comprehensive, patient-centered primary care to patients who live in a medically underserved area. It relates to the regional goals by providing patient-centered, coordinated care. It also uses existing infrastructure by partnering with Pleasant Hill Baptist Church to build a clinic within its existing space.

**Challenges and how to address:**
Clinic leadership will be challenged to develop relationships with other integrated healthcare systems for the provision of specialty and hospital care services and to ensure seamless integration with secondary and tertiary levels of care. The team will partner with other RHP DSRIP participants who are committed to ensuring access for this patient population. All professional staff must be open to developing and learning a new model of providing primary healthcare. One of the core components of the project is to engage all providers in process improvement so as to ensure their commitment to implementing successful care models.

**5-Year Expected Outcome for Provider and Patients:**
The goal is to increase access to primary care with achievement of NCQA recognition of the clinic as a PCMH. Expected outcomes also include improved immunization rates, cervical screening rates, HbA1c control and weight management, overall providing the best opportunity for the health and well-being of this community.

**Starting Point/Baseline:**
This is a new clinic; baseline data are not available and will be determined during the first year of the clinic opening.

**Rationale:**
This project will enhance healthcare value by increasing primary healthcare access to an underserved population of the community and decreasing their use of emergency rooms, as well as hospitalization for downstream complications that can be prevented with timely primary care (ambulatory sensitive conditions). Healthcare value will be enhanced by training learners from multiple healthcare professions in a high-performing, model Patient Centered Medical Home where high quality primary care is provided by an inter-professional team, resulting in more
cost-efficient and higher quality care, i.e. higher value care. This contributes to the RHP goals by increasing access to patient-centered primary care.

**Project Components:**
The Inter-Professional Primary Care Clinic is proposed under option 2.1.1. The following project requirements will be completed over DY 2-5:

a) Utilize a gap analysis to assess the clinic’s NCQA PCMH readiness. The gap analysis will be conducted in DY3 and DY4 in preparation for the NCQA application in DY4-5.

b) Conduct feasibility studies to determine necessary steps to achieve PCMH status. Feasibility studies will be completed in conjunction with the gap analyses.

c) Conduct educational sessions for practitioners, clinic staff and leadership about the PCMH model. Educational sessions will be conducted as new providers are hired and as the clinic prepares to apply for NCQA accreditation. Education will continue as a component of the quality improvement sessions in DY3-5.

d) Conduct quality improvement activities. This will be included as the teams develop and implement evidence-based clinical practice guidelines for the patient population served. Once the guidelines are implemented, they will be reviewed and updated annually based on lessons learned. (I-X.1, I-X.2)

**Milestones & (Metrics):**
- Process Milestones and Metrics: P-4 (P-4.1); P-5 (P-5.1); P-X (P-X.1)
- Improvement Milestones and Metrics: I-17 (I-17.2); I-19 (I-19.2); I-X (I-X.1, I-X.2, I-X.3)

Workforce development is one of the project cornerstones. Designing a curriculum for the inter-professional team is proposed as a DY2 milestone under option P-X. One proposed metric is to enter into agreements with local health professional schools to ensure trainees of all types have an opportunity to learn and participate in a PCMH environment. Subsequent metrics include expanding the number of health professions involved in the inter-professional training. The goal is to ensure many types of healthcare providers are trained in the PCMH model and have an opportunity to participate in care delivery improvement. The inter-professional team will develop evidence-based clinical practice guidelines and monitor patient outcomes monthly to drive process improvement and ensure high quality care. The specific guideline will be determined once the clinic has enrolled patients in order to ensure the guidelines represent the salient health issues of the patient population. Decision support tools (e.g. smart forms) will be embedded within the electronic health record (EHR). The monthly reports will measure adherence to the (process of care) guidelines as well as disease-specific outcomes of care. Success of these implemented guidelines will be measured further in the Category 3 outcomes, such as HbA1c control.

**Unique community need identification number the project addresses:**
- CN1 – Access to primary care
- CN4 – Coordinated care for chronic conditions
- CN6 – Improved immunization compliance

**How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:**
This clinic will transform delivery by training many types of healthcare providers in the PCMH model. All providers will be engaged in process improvement initiatives to ensure the delivery of continuous integrated care. The beneficiaries are patients who live in a medically underserved area, where access to care is limited at best, so this clinic will help fill that gap.

**Related Category 3 Outcome Measures:**
OD-1 Primary Care and Chronic Disease Management
- IT-1.10 – Diabetes care: HbA1c poor control (>9.0%)
- IT-1.20 – Weight management
- IT-12.2 – Cervical cancer screening (HEDIS 2012)

**Reasons/rationale for selecting the outcome measure(s):**
The Fifth Ward has been identified as a medically underserved area\(^1\) and is predominantly comprised of residents who identify themselves as Black, Hispanic or Latino\(^2\). The Category 3 outcome measures selected below each address health care issues that affect minority and poor populations disproportionately. These specific measures are surrogates for the health of the population and will reflect the Fifth Ward Clinic’s success in providing access to and improving utilization of preventive services and improving the health of the community overall. Additionally, prevention and early intervention, particularly in the cases of diabetes, obesity and cervical lesions, can alleviate system health care costs in the long run.

Improvements in HbA1c control, option IT-1.10, can improve patient quality of life and cost of care by reducing the lifetime incidence of blindness, end-stage renal disease (ESRD) and coronary artery disease in patients with type 2 diabetes\(^3\). Black and Hispanic patients have higher rates of diabetes and higher mortality rates due to diabetes\(^4\) than white patients. African Americans are more likely to develop ESRD. The Health of Houston Survey 2010 indicated that the Near Northside-Fifth Ward area of the city has the highest rate of diabetes in the city – 20 percent.

Weight management is a proposed outcome measure under option IT-1.20. According to the Health of Houston Survey in 2010, 32% of Houston area adults were obese, compared to 29% across the State of Texas\(^5\) with a high prevalence among non-Hispanic blacks (51% higher) and Hispanics (21% higher)\(^6\). In the Near Northside-Fifth Ward area, 37 percent of residents are obese – again the highest rate in the city. Obese patients face a higher risk of developing

---


\(^4\) Agency for Healthcare Research and Quality, Diabetes Disparities Among Racial and Ethnic Minorities.


diabetes\textsuperscript{7}, but weight loss can significantly reduce that risk\textsuperscript{8}. Helping patients achieve healthier weights can reduce mortality and morbidity and their attendant costs associated with diabetes.

Improvements in cervical cancer screening, option IT-12.2, can reduce the incidence of cervical cancer by as much as 93\%, while also decreasing associated mortality and lowering treatment costs\textsuperscript{9}. Black and Hispanic women have much higher rates of incidence and mortality when compared to the general population\textsuperscript{10}. Additionally, this will reflect the success of providing access to preventive services at the clinic.

\textbf{Relationship to Other Projects:}
Like the Baylor Teen Health Clinic (project 082006001.1.1), the Fifth Ward Clinic will provide primary care services in a medically underserved area. However, the clinic is situated in a different geographic area and targets the entire family rather than a specific age cohort.

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

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

\textbf{Project Valuation:}
The value of this project was determined by an econometrics assessment of access to primary care, immunizations and cervical screening, as well as the care and risks associated with obesity and diabetes. The value assigned to primary care is based on cost avoidance of emergency room visits. The difference between the cost of an emergency room visit and the cost of a primary care

\textsuperscript{9} U.S. Preventive Services Task Force. Screening for Cervical Cancer: Recommendations and Rationale. \textit{Agency for Healthcare Research and Quality}, 2003, Pub No 03-515A.
visit for primary-care-treatable conditions per visit was calculated for the age groups in question.

Historical data were reviewed to determine the percentage of preventive and acute care visits. Rather than assume that all acute care visits could result in an emergency room visit, the project value conservatively estimates that a fraction of acute care visits results in an avoided emergency room visit. Improvements in HbA1c control were valued based on the current rate of adult diabetes in Houston and the annual differential medical cost savings of controlled and uncontrolled diabetes. The total value was calculated based on the expected improvement in the clinic patient population. The value of weight reduction was calculated based on the percentage of the population that is obese and not currently diagnosed with diabetes. Of those patients, it is expected that a 5-7% reduction in weight will reduce the risk of diabetes by 58%. The annual savings was applied to the number of diabetes cases avoided due to weight management for the duration of the Waiver.

Immunization rate value was based on the recommended doses administered to children by age, the cost of each dose, and the cost savings per dollar spent on immunizations. This value was multiplied by the number of patients expected to be affected (the number of children as a percentage of the total patient population). For vaccines that require additional doses beyond age 2, the total savings were prorated for the remaining duration of the Waiver.

The value of cervical screening was based on the differential costs of treating localized lesions and cancers and treating regional and distant cancers. The initial, interim and pro rata final stage costs are calculated based on the current incidence of cancer rates in Texas and the reduction of invasive rates when screening occurs every two years. The total value for the project was combined and distributed across measures to ensure category 3 outcome measurements comprised 5%, 10%, 15% and 20% of the project value in DY2-5. Distribution among the components was based on the weighted value of the measure.

---

11 School of Public Health, Houston Hospitals Emergency Department Use Study: January 1, 2010 through December 31, 2010, Houston, Texas: University of Texas Health Science Center at Houston, 2012.
13 CDC, Recommended Immunization Schedules for Persons Aged 0 through 19 Years, United States, 2012.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>082006001.2.1</th>
<th>082006001.3.3</th>
<th>082006001.3.4</th>
<th>082006001.3.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved HbA1c Control</td>
<td>Improved Weight Control</td>
<td>Improved Cervical Cancer Screening</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 1 [P-4]: Develop primary care staffing plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [P-4.1]: Expand primary care team member roles</td>
</tr>
<tr>
<td>Goal: Expand primary care team member roles</td>
</tr>
<tr>
<td>Data Source: Job descriptions</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $ 411,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 2 [P-5]: Determine appropriate panel size for provider teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [P-5.1]: Determine panel size</td>
</tr>
<tr>
<td>Goal: Document panel size by provider type and team</td>
</tr>
<tr>
<td>Data Source: Documentation from needs assessment</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $ 411,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 3 [P-X]: Design curriculum and teaching methodology for inter-professional primary healthcare team training</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Milestone 4 [I-19]: Expand medical home principles.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [I-19.2]: Increase number of patient-centered visits.</td>
</tr>
<tr>
<td>Goal: Treat 1,000 patients.</td>
</tr>
<tr>
<td>Data Source: EHR</td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment: $ 424,767</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 5 [I-17]: Population health management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [P-17.2]: Establish baseline percentage of patients receiving recommended immunizations by age 2.</td>
</tr>
<tr>
<td>Data Source: EHR</td>
</tr>
<tr>
<td>Milestone 5 Estimated Incentive Payment: $ 424,766</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 6 [I-X]: Implement evidence-based guidelines and process improvement initiatives.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 [I-X.1]: Implement evidence-based clinical guidelines.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Implement 3 evidence-based guidelines.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 6 Estimated Incentive Payment: $ 424,766</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 7 [I-19]: Expand medical home principles.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [I-19.2]: Increase number of patient-centered visits.</td>
</tr>
<tr>
<td>Goal: Treat 3,000 patients.</td>
</tr>
<tr>
<td>Data Source: EHR / practice management system</td>
</tr>
<tr>
<td>Milestone 7 Estimated Incentive Payment: $ 434,333</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 8 [I-17]: Population health management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [I-17.2]: Increase percentage of pediatric patients receiving recommended immunizations by age 2.</td>
</tr>
<tr>
<td>Goal: Increase by 5% compared to baseline (DY 3).</td>
</tr>
<tr>
<td>Data Source: EHR</td>
</tr>
<tr>
<td>Milestone 8 Estimated Incentive Payment: $ 434,333</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 9 [I-X]: Implement evidence-based guidelines and process improvement initiatives.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [I-X.1]: Implement evidence-based guidelines.</td>
</tr>
<tr>
<td>Goal: Implement 3 evidence-based guidelines.</td>
</tr>
<tr>
<td>Milestone 9 Estimated Incentive Payment: $ 434,333</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 10 [I-19]: Expand medical home principles.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [I-19.2]: Increase number of patient-centered visits.</td>
</tr>
<tr>
<td>Goal: Treat 5,000 patients.</td>
</tr>
<tr>
<td>Data Source: EHR / practice management system</td>
</tr>
<tr>
<td>Milestone 10 Estimated Incentive Payment: $ 330,250</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 11 [I-18]: Obtain NCQA medical home recognition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [I-18.1]: Medical home recognition.</td>
</tr>
<tr>
<td>Goal: Medical home recognition for Fifth Ward Clinic.</td>
</tr>
<tr>
<td>Data Source: Documentation of NCQA accreditation</td>
</tr>
<tr>
<td>Milestone 11 Estimated Incentive Payment: $ 330,250</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 12 [I-17]: Population health management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [I-17.2]: Increase percentage of pediatric patients receiving recommended immunizations by age 2.</td>
</tr>
<tr>
<td>Goal: Increase by 5% compared to baseline (DY 3).</td>
</tr>
<tr>
<td>Data Source: EHR</td>
</tr>
<tr>
<td>Milestone 12 Estimated Incentive Payment: $ 330,250</td>
</tr>
</tbody>
</table>

RHP Plan for Region 3 – Southeast Texas Regional Healthcare Planning
<table>
<thead>
<tr>
<th>Metric 1 [P-X.1]: Enter into collaborative agreements with health professional schools</th>
<th>Data Source: EHR</th>
<th>Data Source: Documentation of collaborative agreements</th>
<th>Milestone 3 Estimated Incentive Payment: $ 411,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 2 [I-X.2]: Report process and outcomes measures monthly. Goal: Implement reports. Data Source: EHR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 6 Estimated Incentive Payment: $ 424,767</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 9 Estimated Incentive Payment: $ 434,334</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount:** $ 1,233,000

**Year 3 Estimated Milestone Bundle Amount:** $ 1,274,300

**Year 4 Estimated Milestone Bundle Amount:** $1,303,000

**Year 5 Estimated Milestone Bundle Amount:** $1,321,000

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over DYs 2-5): $ 5,131,300
Project Option - 2.6.3 Engage community health workers in an evidence-based program to increase health literacy of a targeted population.

Unique Project ID: 0937740-08.2.1

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

Project Summary:
Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

Intervention(s): This new project proposes to utilize community health workers to provide 24 sessions of essential education and assessment related to fall prevention and safety to 500 low income older adults during the baseline year. Based on other home visitation programs, the population is expected to be 90% being Black or Hispanic. The program will also provide intervention to reduce hazards in the home to 100 of the 500 low income older adults initially recruited into the program.

Need for the Project: The risk for a fall increases exponentially with advancing age. Older adults often seek care at the ER for falls related injuries that are preventable. Preventing falls requires a multifactorial approach with assessment and management. This program will provide education, evaluation/assessment and fall-related hazard mitigation at home and follow up by identifying hazards that impair safety and health in the home as part of an evidence-based fall prevention intervention.

Target Population: The project will target older adults aged 60 and referrals and recruitment to this program will be generated by home visitation programs of the performing provider or its partners such as Harris County Area Aging Agency (HCAAA), Houston Department of Health &Human Services (HDHHS)Tuberculosis (TB) Control and other departmental(Communicable Diseases, etc.) and the target population is expected to be 80% Medicaid.

Category 1 or 2 expected patient benefits: Increase access to health promotion programs and activities using innovative program by 5% in DY4 from 500 to 525 home safety educations and from 100 to 105 home inspections and by 10% in DY5 to 550 home safety educations and 110 home inspections.
Category 3 outcomes: **IT-9.4:** (ED appropriate utilization) IT-9.4 Milestone: Other Outcome Improvement Target (ED appropriate utilization – Stand-alone measure)

1) Home Safety/ Perception of Home Safety survey to complete while inspecting homes; and of patients who undergo home inspection, do follow-up calls to determine retention.

2) The number of falls among program participants since the inspection.

3) The % of falls, that resulted in 9-1-1 calls and/or ED visits among program participants. Reduce by 5% each the number of ED visits among program participants and number of 911 calls made for falls in older adults 60 years and over from specific zip codes over baseline in DY4 and by 10% over baseline in DY5.

**Project Option - 2.6.3 Engage community health workers in an evidence-based program to increase health literacy of a targeted population: Healthy Homes Fall Prevention Initiative**

**Unique Project ID:** 0937740-08.2.1

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

**Project Description:**

The Healthy Homes Fall Prevention (HHFP) project proposes to utilize community health workers to provide essential education related to fall prevention and safety as critical components to the health and well-being of older adults (60+ years) in the community and prevent unnecessary ER usage for preventable falls in the home. This initiative will follow a three-pronged approach: education, evaluation/assessment and follow up. This initiative will engage community health workers in an evidence-based program to increase health literacy of a targeted population. One innovative aspect of the initiative is follow-up home visiting for referrals generated by programs that already visit homes of older adults in specific high-risk zip codes that have a disproportionately high number of ER visits for falls. Through partnerships with other Houston Department of Health and Human Services (HDHHS) programs, at-risk older adults will be identified and enrolled in the HHFP Initiative. Issues addressed by the Safe and Healthy Homes concept are critical to the ability of seniors to age safely in place and to enjoy improved quality of life. Educating older adults on the principles of healthy homes will promote reduction of hazards in the home environment; reduce emergency room visits and reduce costs of rehabilitation. Additionally, education will be provided for home care givers to help reinforce the principles of healthy homes.

Many older adults seek care at the ER several times a year for fall related injuries. Preventing falls requires a multifactorial approach with assessment and management (CDC, 2012). The HHFP program proposes to utilize an evidence based approach of home hazard assessment and education for reducing the risk of falling. The average cost of emergency room visit for adults (aged 50-85 years) due to unintentional falls in the US, is estimated to be $3323 per visit. This is inclusive of Medical Cost and Work Loss Cost.¹ The project will target 500 older adults aged 60 and over and provide education on the value of a safe and healthy home by identifying hazards that impair safety and health in the home, per year. Program staff will also perform 100 home inspection interventions to evaluate safety in the home, perform needs assessments, conduct periodic follow up inspections, facilitate limited remediation and refer seniors to other support programs to reduce hazards, per year.
The referrals to HHFP will be generated through currently existing programs such as Harris County Area Aging Agency (HCAA), the Houston Fire Department (HFD)/Emergency Medical Team (EMT), Houston Department of Health & Human Services (HDHHS) Tuberculosis (TB) Control and other departmental (Communicable Diseases, etc.) home visiting programs.

**Goals and Relationship to Regional Goals:**

**Project Goals:**

The primary goal of this program is to prevent fall related accidents that result in Emergency Room (ER) visits

- Educate older adults on principles of Healthy Homes
- Reduce environmental hazards in the home
- Prevent fall related accidents that result in Emergency Room (ER) visits
- Reduce 9-1-1 calls to the Houston Fire Department

This project meets the following regional goal by implementing an education and follow-up model that prevents falls and potential unnecessary emergency room visits for older adults:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.\(^1,2\)

**Challenges:**

Some of the challenges anticipated with implementation of this initiative include difficulty in gaining trust of older adults and convincing them to modify behaviors that lead to poor health outcomes. The project will build upon relationships already established by referring program staff and use evidence based models that will lead to behavior modification.

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

The performing provider expects a reduction in the number of ER visits and calls to EMT for preventable injuries (e.g., falls)

**Starting Point/Baseline:**

In 2010, the overall rate of nonfatal fall injury episodes for which a health-care professional was contacted was 43 per 1000 persons. Persons aged > 75 years had the highest rate (115 per 1000 persons). Because this is a new initiative, a new baseline for the population that is the target of this project will be established in Year 3 in order to determine improvements and project effectiveness in subsequent years.

1. **Stakeholder input from RHP 3 Working Group Members throughout the Region** (including providers, consumers, hospital and clinic administrators, government officials, researchers, and advocacy groups)

2. **The State of Health – Houston and Harris County, 2012.**

**Rationale:**

The average cost of emergency room visit for adults (aged 50–85 years) due to unintentional falls in the US, is estimated to be $3323 per visit. This is inclusive of Medical Cost and Work Loss Cost. With an estimated 350 high risk individuals enrolled by the HHFP program, assuming that the program could prevent even one ER visit per year/person for unintentional falls in our enrolled population, the cost savings to the ER and the Health care system is $1,163,050 per
year. Nationally, falls account for 52.4% of unintentional injuries (HCUP, 2012). In Texas, 46.7% of unintentional injuries were due to falls (Healthcare Cost and Utilization Project, 2012)\(^1\).

Risk for suffering a serious fall related injury increases exponentially with advancing age. Nationally, approximately one third of elderly adults experienced a fall (Hausdorff et al., 2001)\(^2\) each year. Older adults comprise a large number of ER visits due to falls. Even more disconcerting is the fact that there has been a sharp year to year increase in the number of fatal falls in older adults in the past 10 years. Many older adults seek care at the ER several times a year for fall related injuries. Preventing falls requires a multifactorial approach with assessment and management (Centers for Disease Control, 2012)\(^3\). The HHFP program proposes to utilize one such evidence based approach of home hazard assessment and education for reducing the risk of falling.

In 2010, the overall rate of nonfatal fall injury episodes for which a health-care professional was contacted was 43 per 1,000 population. Persons aged ≥75 years had the highest rate (115 per 1000).\(^3\) The direct medical costs for fall related injuries nationally is about $20 billion annually and is expected to increase substantially over the next decade as the population ages.

**Project Components:** There are no required project components for the project option.

The Healthy Homes project will put in place a Quality Improvement process that will continuously evaluate and improve processes for improvement. This is particularly necessary since this is a new program and there will be need to clarify procedures, revise protocols, and additional training of staff. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes. A Plan-Do-Study-Act cycle with an initial intervention implementation on a small number of target population members and gradually scaling up to greater numbers is an essential component of this methodology. This will enable this program to recognize successes and failures early in program implementation and correct them as necessary.

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

The Healthy Homes Initiative also addresses the issues addressed in the following community needs assessments:

- CN.8 High rates of inappropriate emergency department utilization\(^1,2\)
- CN.23 Lack of patient navigation, patient and family education and information programs\(^1,2\)

---


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

---

Regional Healthcare Partnership Plan Region 3 961
The project is a new innovation which provides services in the home to reduce falls and potential ambulance transports and emergency room visits.

**Related Category 3 Outcome Measures:**

- OD-9 – Right Care, Right Setting
- IT-9.4 Milestone: Other Outcome Improvement Target (ED appropriate utilization – Stand-alone measure)
  1. Home Safety/Perception of Home Safety survey to complete while inspecting homes; and of patients who undergo home inspection, do follow-up calls to determine retention.
  2. The number of falls among program participants since the inspection.
  3. The % of falls, that resulted in 9-1-1 calls and/or ED visits among program participants.

**Reasons/rational for the selecting the outcome measures:**

We chose the “Other Outcome Improvement Measure” as our outcome because of the prevalence of falls among older adults due to structural conditions in the home that are preventable and remediable. According to the United States Preventive Task Force recommendations, decreasing the incidence of falls would also improve the socialization and functioning of older adults who have previously fallen and fear falling again. The burden of falls on patients and the health care system is large. Decreasing the incidence of falls would also improve the socialization and functioning of older adults who have previously fallen and fear falling again. Many other interventions could potentially be useful to prevent falls, but because of the heterogeneity in the target patient population, multiplicity of predisposing factors, and additive or synergistic nature, their effectiveness is not known. Despite this, a cost effective solution to avoid falls in older adults and the subsequent inappropriate usage of ER, a comprehensive Fall Prevention intervention in high risk communities is relatively easy to implement.

**Relationship to Other Projects and Plan for Learning Collaborative:**

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

Healthcare treatment cannot focus to only the acute or chronic encounter and properly treat the patient. It is critical that our region focuses to patient education and community education to ensure a proactive and responsive approach to healthcare needs. The education models represented in the Region 3 RHP plan can be identified in the Initiative Grid (addendum) and all focus to outcome measures such as appropriate utilization, patient satisfaction scores, and standalone chronic condition scores such as diabetes and asthma.

**Project Valuation:**

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

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

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The Healthy Homes Fall Prevention project received a composite Prioritization score of 5.4 and a Public Health Impact score of 6.
**Project Title: Healthy Homes Fall Prevention Initiative**

<table>
<thead>
<tr>
<th>Performing Provider Name: City of Houston Department of Health and Human Services</th>
<th>HDHHS -0937740-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 3 Outcome Measures:</td>
<td>0937740-08.3.4</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
</tr>
<tr>
<td>Milestone 1 [P –X]: Complete a planning process for the implementation of a program to educate the elderly in fall prevention, engage partners, identify current capacity and resources needed, and develop a timeline</td>
<td><strong>Milestone 4</strong> [P-4]: Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned.</td>
</tr>
<tr>
<td>Metric 1 [P-X.1]: Development of a report documenting implementation plans, partnerships and necessary resources, and implementation timeline</td>
<td>Goal: Completion of planning process and report Data Source: Completed report that includes information identified above</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $593,798.23</td>
<td><strong>Milestone 5</strong> [P-5]: Execution of evaluation process for project innovation.</td>
</tr>
<tr>
<td>Milestone 2 [P-1]: Conduct a needs assessment to identify the Conduct an assessment of health promotion programs that involve community health workers at local and regional levels.</td>
<td>Metric 1 [P-5.1]: Document evaluative process, tools and analytics. Goal: Initiate evaluation of programs and connections/referrals to care for target population Data Source: Program documentation</td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment: $987,173.10</td>
<td><strong>Milestone 6</strong> Estimated Incentive Payment: $1,050,890.02</td>
</tr>
</tbody>
</table>

**Regional Healthcare Partnership Plan**

Region 3

964
### Project Title: Healthy Homes Fall Prevention Initiative

<table>
<thead>
<tr>
<th>Performing Provider Name: City of Houston Department of Health and Human Services</th>
<th>HDHHS -0937740-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 3 Outcome Measures:</td>
<td>0937740-08.3.4</td>
</tr>
<tr>
<td>Other Outcome Improvement Target</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

- **Goal:** Determine the need and scope of fall prevention program.
- **Data Source:** Program documentation, needs assessment survey

**Metric 1** (P-X2.1): Document selection of evidence-based innovative Fall prevention strategy and plan.

**Goal:** Select appropriate Fall Prevention intervention for target population

**Data Source:** Program Documentation

| Milestone 2 Estimated Incentive Payment: $593,798.23 |

**Milestone 3** [P-X2]: Select evidence-based Healthy Homes – Fall Prevention initiative for older adults using best practice guidelines

**Data Source:** Program Documentation

**Milestone 3 Estimated Incentive Payment: $593,798.23**

**Numerator:** Total number unique patients in defined population who received innovative Fall Prevention intervention

**Denominator:** Total number of patients in defined population referred to Fall Prevention Program.

**Data Source:** Program Documentation

**Milestone 4 Estimated Incentive Payment: $1,490,097.79**

**Milestone 5 Estimated Incentive Payment: $987,173.10**

**Numerator:** Total number of unique patients in defined population who received innovative Fall Prevention intervention

**Denominator:** Total number of patients in defined population referred to Fall Prevention Program.

**Data Source:** Program Documentation

**Milestone 6 Estimated Incentive Payment: $1,490,097.79**

**Milestone 7 Estimated Incentive Payment: $1,050,890.02**

**Numerator:** Total number of unique patients in defined population who received innovative Fall Prevention intervention

**Denominator:** Total number of patients in defined population referred to Fall Prevention Program.

**Data Source:** Program Documentation

**Milestone 8 Estimated Incentive Payment: $1,490,097.79**

**Milestone 9 Estimated Incentive Payment: $1,015,593.96**

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $7,888,708.84**
Project Option 2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care

Unique Project ID: 0937740-08.2.2

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

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. A similar pilot navigation program served 1074 clients last year, of which 60% were Medicaid patients, 15% were completely uninsured, 60% were African American, 30% were Hispanic and 8% were White and 2% were other race/ethnicity. This expansion project will serve 2000/year from DY4-5.

Intervention(s): CareHouston Links is a new program that proposes to provide care coordination and navigation that will reduce the frequency of non-urgent ambulance runs and ER visits and link 911 callers to appropriate primary and preventive care in lieu of unnecessary emergency room care.

Need for the Project: Current data shows that there are over 100,000 non-emergency transports made by Houston Fire Department (HFD) with certain zip codes having a high percentage of 911 calls. The CareHouston Links project will expand a program that has proven to reduce repeat calls to 911, through the use of face to face follow-up, education and navigation services among those with non-emergent conditions.

Target Population: All individuals that utilize Emergency Room (ER) for non-emergent, primary care needs and are transported by ambulance to the ER, will benefit from this project.

Category 1 or 2 expected patient benefits: During DY3, the program will enroll 80 patients/months in the navigation program. If patients were enrolled on target for 12 months of DY3, then the total number enrolled for DY3 would be 960. Our goal is to increase number of patients enrolled by 5% over baseline in DY4 (to 1008 new patients/year) and 10% over baseline numbers in DY5 (to 1056 new patients/year) the number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services, and enrolled in the program.

Category 3 outcomes:
IT-9.4: Other Improvement Target (ED Appropriate utilization for those needing non-emergent care and transported by ambulance and enrolled in this program). Our goal is to reduce by 5% below baseline the proportion of non-emergent ED visits (arrived by ambulance transportation) in DY4 and 7% below baseline in DY5 among those enrolled in the program.

Project Option 2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.

Unique Project ID: 0937740-08.2.2
Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Description:
CareHouston Links proposes to provide care coordination that will reduce the frequency of non-urgent ambulance runs and ER visits and link 911 callers to appropriate primary and preventive care in lieu of unnecessary emergency room care.

CareHouston Links is an expansion of the CareHouston program that was launched as a partnership between the Houston Department of Health Human Services (HDHHS) and the Houston Fire Department (HFD) Emergency Medical Services in 2006. CareHouston Links will expand the existing program throughout the City of Houston and integrate its services with the HFD Emergency TeleHealth and Navigation (ETHAN) Program. CareHouston Links will provide case management support to ensure clients who were referred by the ETHAN program receive appropriate follow up care and are linked to a medical home. The CareHouston Links navigators will follow up with the patient to determine if the patient followed the advice provided by the ETHAN physician. The counselor/case manager will work with the client/family and their health care provider to ensure continued compliance. In situations where the client failed to follow the advice provided, the counselor will determine and record what actually occurred and the reasons why the advice was not carried out. The counselor will assess these issues and develop a care plan to address them and ensure clients are linked to the appropriate care. Additionally, the CareHouston Links program would continue the education and referral services that were provided to frequent 911 callers through the CareHouston program.

CareHouston Links is designed to address the challenges that are faced by the City of Houston in providing emergency health services to the residents of the City of Houston. According to a report from 2008, from University of Texas School of Public Health, visits to the ER were rising due to primary care cost rising. In 2008, 10.8% of all primary care related ED visits arrived by ambulance transport and 20.9% of all other ED visits arrived by ambulance. Current data shows that there are over 100,000 non-emergency transports made by HFD. HFD has also documented certain zip-codes that have a high percentage of 911 calls. The CareHouston Links project addresses these challenges by expanding a program that has proven to reduce repeat calls to 911 and thereby reducing the use of expensive emergency services through the use of face to face follow-up, education and navigation services. The new program will build upon these past successes and not only reduce 911 calls and ambulance runs but also link callers with primary care resources as an alternative to use of expensive emergency services.
The zip codes that generate a large volume of 911 calls that are non-emergent will be a primary target for this program. These zip codes will be identified by the Houston Fire Department and Emergency Medical Services data system for the previous year. The pilot was conducted in 77051 and 77033 which comprise the Sunnyside neighborhood in Houston. The methods were validated for two pilot zip codes.

**Goals and Relationship to Regional Goals:**
The goal of this project is to utilize community health workers, case managers, or other types of health care professionals as patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. These patient navigators will help and support these patients to navigate through the continuum of health care services. Patient Navigators will ensure that CareHouston Links patients receive coordinated, timely, and site-appropriate health care services and will assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations.

**Project Goals:**
1. Expand CareHouston program to other targeted low income, underserved high risk communities and partner with the ETHAN (Telehealth) Program.
2. Enhance service to the community by reducing inappropriate emergency room visits
3. Increase the number of clients appropriately linked to a medical home
4. Increase the number of clients consistently using their medical home
5. Reduce the need for hospitalizations and improve the quality of life of clients.

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

**Challenges:**
The performing provider anticipates challenges in educating patients and families to use the program, working with Houston Fire Department and other EMS/Ambulance Services to meet alternative transportation needs of clients and overcoming barriers (such as appointment wait times) to link patients to a medical home. Additionally, the provider anticipates system capacity challenges that may be encountered by clients in follow-up on referrals for other needed services. The provider will seek to form ongoing working partnership with others providers of health care and social services to develop workable solutions to anticipated barriers.

**5 Year Expected Outcome for Provider and Patient:**
The CareHouston Links Program expects to reduce the number of ER visits and 911 calls to EMS for non-emergencies in high volume zip codes and thereby reduce costs to the health care system. The program also expects that patients will be linked to medical homes and be appropriately educated and supported to access services in the right setting.
**Starting Point/ Baseline:**
The number of referrals to CareHouston program in YR 2 will be used as an initial baseline for the program.

**Rationale:**

The CareHouston Links project will utilize health care workers, case managers/workers or other types of health professionals needed to engage with patients in a culturally and linguistically appropriate manner which is essential to guiding patients through integrated health care delivery systems. Patient navigators help patients and their families navigate the fragmented maze of doctors’ offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system. Referrals are made to social services, home health care services, FQHCs and other medical homes, as indicated. Additional follow-up in the CareHouston Links program would include home visits and patient education that would ensure that the clients are linked to appropriate services. Other assistance would include referrals to private ambulance services and Harris County rides to avoid inappropriate use of EMS and provide care coordination. Linking, assessing and referring clients to appropriate services will reduce their need to use 9-1-1 services. This program will facilitate communication among patients, family members, survivors and healthcare providers; coordinate care among providers; arrange financial support and assisting with paperwork; arrange transportation and child care; ensure that appropriate medical records are available at medical appointments; facilitate follow-up appointments and conduct community outreach and build partnership with local agencies and groups.

Cost savings from this program include savings related to reduction in ED use and redirecting and connecting patients to medical homes and services for chronic care management and reduction in EMS transports. The target group for this project are residents who access emergency services for circumstances that would be more appropriately addressed through alternative systems of care. Annually, the HFD makes over 100,000 transports for non-emergency reasons. The results from the currently ongoing CareHouston program are a robust indicator that patient navigation services are a viable solution to the challenge of assuring that residents access primary and preventive services in lieu of emergency services where appropriate. The challenge that led to the development of the CareHouston program was the observation by HFD EMS personnel that they were making frequent ambulance runs to the same addresses and seeing no long term solution to the client’s health issues. The medical director of Houston’s EMS services, who also serves as the Public Health Authority, was familiar efforts by the HDHHS to assess and meet health and social service with targeted outreach initiatives in the community. To document the challenge and the effectiveness of the intervention, HFD reviewed data from April 1, 2006-June 30, 2006 for the targeted pilot area, the Sunnyside community and found that 18 patients accounted for 113 EMS responses via 9-1-1 during this period. These patients were referred to the HDHHS and were contacted in the first part of July. These same patients were reevaluated for 911 service requests at the end of September. Following contact by HDHHS personnel, the 18 addresses/patients (including several who declined participation in the program), accounted for only 33 responses, a decrease of 70.80%. Eight of the 18 study patients, approximately 40% of the identified patients, had no requests for 911 services. Through the CareHouston program, frequent 911 callers identified by HFD are referred to HDHHS for follow-up by HDHHS navigators and case managers. Clients are assessed to determine underlying problems such as lack of education regarding health condition or transportation...
needs. HDHHS staff educates residents and families about their health and medical condition, the proper use of the EMS system, alternate transportation services and any other unmet needs. Referrals are made to social services, home health care services and medical homes, as indicated. The program is staffed by counselors, navigators and public health nurses who reach out to the individuals referred through phone, mail, home visits or the HFD/EMS Services.

**Project Components:**

CareHoustonLinks program will address all of the following project components defined for the project option 2.9.1 to establish/expand a patient care navigation program.

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency. The program will provide appropriate training and education to patient navigators so that they are equipped to address the needs of multiple racial/ethnic and socio-economically diverse populace of Houston.

b) Deploy innovative health care personnel, such as community health workers and other types of health professionals as patient navigators. The program will have a strong community base component so that there is greater buy in from the target communities.

c) Connect patients to primary and preventive care. The patient navigators will be skilled in connecting patients to primary care and will follow up to ensure that patients are making the primary care visits.

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management. Since many of the patients that will be enrolled in the program are expected to have multiple chronic conditions, navigators will connect them to disease self-management programs that currently exist in the community.

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

The performing provider will utilize trained health care navigators to identify ED users, increase access to care management and education programs, reduce ED use and non-emergency ambulance runs and connect patients to primary and preventive care. HDHHS will build upon the experience and success of the CareHouston program to implement the CareHouston Links program. Additionally, HDHHS will conduct quality improvement activities for the project as described in the RHP planning protocol.

The performing provider will also institute a Plan-Do-Study-Act cycle in place. This will address Quality Improvement (QI) on a consistent basis. The study protocol, processes and staff training will be tested as a pilot in DY3. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes. Thorough documentation of processes will ensure followup for quality improvement. This will give the program an opportunity to make modifications and improvements as needed by the time the outcomes (Improvement Targets) are beginning to be tracked in DY4-5. The QI process will happen on a continual basis.

**Unique community need identification numbers the project addresses:**
• CN-8 High rates of inappropriate emergency department utilization
• CN-20 Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
• CN-23 Lack of patient navigation, patient and family education and information programs.

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

The existing CareHouston program has been reprogrammed as CareHouston Links. Both the existing CareHouston program as well as the reprogrammed CareHouston Links does not utilize any other sources of federal funding. The program will be expanded to include the following: 1) addition of patient care teams to expand the number of patients that can be seen in the program 2) an increase in referrals to the program to include not only frequent 911 callers but also callers that were determined through the telehealth program to need an alternative form of care other than emergency room care 3) a more robust follow-up program to not only make referrals to medical homes but also provide actual navigation support and follow-up to connect clients to medical homes and to assure usage 4) an increase in the number of 911 callers referred to the program by changing the criteria for inclusion in the program.

**Related Category 3 Outcome Measures:**

OD- 9 Right Care, Right Setting

IT-9.4 Other Outcome Improvement Target (ED appropriate utilization due to enrollment in CareHouston Links Program)

• Rate of Non Emergent 911 callers referred to CareHouston Links

**Reasons/rationale for selecting the outcome measures:**

We chose the above outcome measure because it will allow us to track the tangible benefits of implementation of CareHouston Links. Since the CareHouston program’s implementation in 2006, the HFD EMS unit has experienced a 72% decrease in 911 calls from specific geographic areas allowing them to redirect more than $4.6 million to other services.

By expanding to other targeted low income, underserved high risk communities, with a large volume of 911 calls, the program could expand HDHHS’s capacity to connect and link clients to needed services in a timely manner and further reduce costs associated with non-emergency EMS transports and inappropriate ER visits. Linking, assessing and referring clients to appropriate services will reduce their need to use 911 services. Each time an ambulance service is dispatched to transport patients; the cost is approximately $1470. During Fiscal Year 2012, the Care Houston program diverted 1,458 clients from using EMS transports to emergency departments for non-emergencies, diverting costs of $2,143,260.

**Relationship to Other Projects and Plan for Learning Collaborative:**

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

The ability to properly identify and monitor specific patients with chronic conditions or frequent emergency department utilization trends will allow the region to accurately manage the...
very large patient base. Patient navigation includes a comprehensive list of tasks as well as unique provider types based on the focus of the initiative and will help the focus of cost containment, emergency department utilization, and chronic disease management. The Region 3 Initiative Grid in the addendum allows for a cross reference of all initiatives proposed within this concept.

**Project valuation:**

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

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

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The CareHouston Links Program received a composite Prioritization score of 7.15 and a Public Health Impact score of 7.
<table>
<thead>
<tr>
<th>Milestone 1 [P – X1]: Plan scope, range, current capacity and needed resources for CareHouston Links</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1: Provide report detailing Program Planning Materials, Meeting minutes, Sign-in sheets, Draft Clinical Protocols, Staff Qualifications, Staffing Plan</td>
</tr>
<tr>
<td>Goal: Produce a comprehensive report documenting all points above</td>
</tr>
<tr>
<td>Data Source for Milestone 1: Program Documentation</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $732,540.13</td>
</tr>
<tr>
<td>Milestone 2 [P – X 2]: Establish Baseline data for the number of non-emergent calls and visits that are the target of this program for a 12 month period.</td>
</tr>
<tr>
<td>Milestone 4 [P-3]: Provide care management/navigation services to targeted patients.</td>
</tr>
<tr>
<td>Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program</td>
</tr>
<tr>
<td>Baseline: Establish baseline number of patients enrolled in program</td>
</tr>
<tr>
<td>Data Source: Enrollment reports</td>
</tr>
<tr>
<td>Numerator: Number of targeted patients enrolled in the program</td>
</tr>
<tr>
<td>Denominator: Total number of targeted patients identified</td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment: $1,217,827.67</td>
</tr>
<tr>
<td>Milestone 5 [P-X]: Establish baseline number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services.</td>
</tr>
<tr>
<td>Metric 1 [P-X.1]: Collect data to establish baseline number of 80 new patients/month for PCP referrals for patients without a medical home who</td>
</tr>
<tr>
<td>Goal: Increase by 5% over baseline (to 1008 new patients in DY4) the number of patients that were given PCP referrals</td>
</tr>
<tr>
<td>Data Source: Performing Provider administrative data on patient encounters and scheduling records from CareHouston Links patient navigator program.</td>
</tr>
<tr>
<td>Numerator: Number of new patients referred for services from Patient Navigator Program (CareHouston Links) that are seen in primary care setting and empanelled to the medical home.</td>
</tr>
<tr>
<td>Denominator: Number of new patients referred for services from Patient Navigator Program (CareHouston Links) from repeat 911</td>
</tr>
<tr>
<td>Milestone 6 [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services.</td>
</tr>
<tr>
<td>Metric 1 [I-6.1]: Increase medical home empanelment of patients referred from navigator program.</td>
</tr>
<tr>
<td>Goal: Increase by 5% over baseline (to 1008 new patients in DY4) the number of patients that were given PCP referrals</td>
</tr>
<tr>
<td>Data Source: Performing Provider administrative data on patient encounters and scheduling records from CareHouston Links patient navigator program.</td>
</tr>
<tr>
<td>Numerator: Number of new patients referred for services from Patient Navigator Program (CareHouston Links) that are seen in primary care setting and empanelled to the medical home.</td>
</tr>
<tr>
<td>Denominator: Number of new patients referred for services from Patient Navigator Program (CareHouston Links) from repeat 911</td>
</tr>
<tr>
<td>Year 2</td>
</tr>
<tr>
<td>--------</td>
</tr>
</tbody>
</table>

**Metric 1**: Number of non-emergent 911 calls by zip code

**Metric 2**: Number of non-emergent ED visits by zip code

Baseline: the total number of Year 2 calls and visits (12 months) by zip code

Milestone 2 Estimated Incentive Payment: $732,540.13

Milestone 3 [P-2.1]: Expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education.

Milestone 3 [P-2.1]: Number of people trained as patient navigators.

Goal: Complete workforce development plan

Data Source: Documentation of use the ED, urgent care, and/or hospital services.

Baseline: Establish percentage of patients that were given PCP referrals

Data Source: Performing Provider administrative data on patient encounters and scheduling records from CareHouston Links patient navigator program.

Milestone 5 Estimated Incentive Payment: $1,217,827.67

Milestone 6 Estimated Incentive Payment: $2,595,864.29

Patient Navigator Program (CareHouston Links) from repeat 911 callers.

Milestone 7 Estimated Incentive Payment: $2,505,778.22

Data Source: Documentation of use the ED, urgent care, and/or hospital services.

Baseline: Establish percentage of patients that were given PCP referrals

Data Source: Performing Provider administrative data on patient encounters and scheduling records from CareHouston Links patient navigator program.
<table>
<thead>
<tr>
<th>0937740-08.2.2</th>
<th>2.9.1</th>
<th>2.9.3(a-c)</th>
<th>PROJECT TITLE: CareHouston Links</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing Provider Name: City of Houston Health and Human Services</td>
<td></td>
<td></td>
<td>TPI - 0937740-08</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>0937740-08.3.5</td>
<td>IT – 9.4</td>
<td>Other Outcome Improvement Target (ED appropriate utilization)</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
</tr>
<tr>
<td>workforce development plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 3 Estimated Incentive Payment: $732,540.13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $2,197,620.39</td>
<td>Year 3 Estimated Milestone Bundle Amount: $2,435,655.33</td>
<td>Year 4 Estimated Milestone Bundle Amount: $2,592,864.29</td>
<td>Year 5 Estimated Milestone Bundle Amount: $2,505,778.22</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> <em>(add milestone bundles amounts over DYs 2-5): $9,731,918.23</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Project Summary:** The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs.

**Intervention(s):** This expansion project will use patient navigators to connect 270 new at risk HIV diagnosed individuals to appropriate care in the baseline year. Linkage to care will consist of active referrals to primary medical care, mental health, substance abuse, support services, and services for basic needs such as food and housing. Utilizing a Community-Based (Non-Medical) Case Management model, this program will also identify frequent ED utilizers and use navigators as part of a preventable ED reduction program.

**Need for the Project:** Newly diagnosed HIV patients are frequently at risk for receiving fragmented care because of being disconnected from the health care system. This project will support HIV patients through the continuum of health care services so that patients can receive coordinated, timely services when needed with smooth transitions between health care settings. The race/ethnicity of patients in HIV linkage program last year were 68% African American, 29% Hispanic and 3% White.

**Target Population:** Newly diagnosed HIV patients will be the target group for this project. In particular, belonging to high risk groups such as males, blacks/African Americans, and Injection drug users will be the targets because they are known to have lower service linkage rates than the average for the Houston region.

**Category 1 or 2 expected patient benefits:** Increase number of PCP referrals for indigent or Medicaid patients without a medical home who use the ED, urgent care, and/or hospital services by 5% over baseline (baseline of 275 patients) in DY4 (288 patients in DY4) and by 10% over baseline in DY5 (303 patients in DY5).

**Category 3 outcomes:**

**IT-9.4:** (ED appropriate utilization) Reduce by 5% each the number of ED visits among program participants in HIV Linkage Program and number of from specific zip codes over baseline in DY4 and by 10% over baseline in DY5.
Project Option 2.9.1- Establish/Expand a Patient Care Navigation Program: HIV Service Linkage Expansion Program

Unique Project ID: 0937740-08.2.3
Performing Provider Name/TOI: City of Houston Department of Health and Human Services / 0937740-08

Project Description:
This Program will expand service linkage to provide navigation services to targeted patients with HIV who are at high risk of disconnect from institutionalized health care.

This project will use patient navigators to connect at risk HIV diagnosed individuals to appropriate care. Linkage to care will consist of active referrals to primary medical care, mental health, substance abuse, support services, and services for basic needs such as food and housing. Utilizing a Community-Based (Non-Medical) Case Management model, this program will also identify frequent ED utilizers and use navigators as part of a preventable ED reduction program.

The Houston Area has placed a high priority on ensuring early linkage into HIV clinical care and treatment for those newly diagnosed through widespread HIV testing and awareness efforts. For example, a unique local service category within the Ryan White HIV/AIDS Program for linking the newly diagnosed into HIV clinical care (e.g., Service Linkage Workers) was created in 2008. Current estimates of those linked to care in the Houston Area are as follows:

1. Of newly diagnosed HIV infected individuals diagnosed in the Houston Area, 65.1 percent linked to HIV clinical care within the national standard of three months following diagnosis. The Houston area rate falls below the average for the state of Texas as a whole (68.6 percent) as well as the national target (85.0 percent).

2. Certain demographic groups in the Houston Area have lower than community-wide aggregate linkage to care rates. Known at risk groups such as males, blacks/African Americans, and Injection drug users (IDU) all have linkage to care rates below the Houston area average. Those in the age category of 13 to 24 years also have a lower than average linkage to care rate.

The Houston Area has adapted the Case Management (Non-Medical) service category for the purpose of linking the newly-diagnosed into primary HIV medical care. Defined locally as Community-Based (Non-Medical) Case Management, services provided under this adapted category are called Service Linkage. Service Linkage Workers (SLW) or patient navigators are often co-located at HIV testing sites.

The Houston area places a high priority on widespread access to HIV testing in both targeted and routine settings, using all available technologies. The Expanded Testing Initiative (ETI) supports routine opt-out HIV screening at local emergency rooms; and community-based organizations provide targeted counseling and testing to those at high risk. Of all publicly-funded HIV tests offered in the Houston Area in 2010, 1.2 percent were positive, which translates into almost 600 HIV+ individuals who became aware of their status in that year alone. The Ryan White HIV/AIDS Program Part A contracts with the HDHHS to place service linkage workers at HDHHS locations where individuals are newly-diagnosed, including routine HIV testing sites at...
local emergency rooms and medical institutions and public STD clinics, for the purpose of linking these individuals to HIV care, treatment, and support services. The Service Linkage Worker Outcome Measure requires each newly-diagnosed client to be linked to a Ryan White HIV/AIDS Program-funded primary medical care or case management provider within 120 days of contact.

Houston Department of Health and Human Services (HDHHS) is currently funded by the Ryan White HIV/AIDS Program to employ Service Linkage Workers (SLW) who connect newly-diagnosed individuals to Ryan White HIV/AIDS Program-funded primary HIV medical care. SLWs at the HDHHS are also cross-trained in disease investigation and can provide partner services for the newly-diagnosed. SLWs also provide referrals to non-HIV related services such as those for co-morbid conditions, behavioral health concerns, and social support services including housing, food, employment, transportation, and child care.

This Performing provider currently serves 300 HIV patients that are at or below 300% of Poverty Level through the Ryan White HIV/AIDS Program. This program implemented by the 1115 Waiver incentive will expand the current linkage program to serve 275 additional new HIV patients who do not meet eligibility requirements for Ryan White funding (i.e. at or below 300% of poverty and non-Medicaid eligible). Therefore, indigent individuals or those that are on Medicaid will be served by this HIV Linkage Program.

The performing provider will also institute a Plan-Do-Study-Act cycle in place for this expansion program. This will address Quality Improvement (QI) on a consistent basis. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes. The study protocol, processes and staff training will be tested as a pilot in DY3. Thorough documentation of processes will ensure followup for quality improvement. This will give the program an opportunity to make modifications and improvements as needed by the time the outcomes (Improvement Targets) are beginning to be tracked in DY4-5. The QI process will happen on a continual basis.

**Goals and Relationship to Regional Goals**

The goal of this project is to utilize patient navigators (called Service linkage workers) to provide targeted, non-medical community-based case management, including active referrals to primary medical care, mental health, substance abuse, support services, and services for basic needs such as food and housing for newly diagnosed HIV patients in a geographic area with low rates of linkage to care for the target population.

**Project Goals:**

The overall goal of the project is to help and support HIV patients through the continuum of health care services so that patients can receive coordinated, timely services when needed with smooth transitions between health care settings. The project will expand access to the existing care management program for individuals who are HIV positive.

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

Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system,

**Challenges**

The program anticipates some challenges in implementation of the program. Some of these challenges are successful hiring and training of new staff for the program, maintaining ongoing collaboration with primary care providers and ensuring clients have access to immediate medical care when necessary to avoid hospitalization and developing a system that will ensure ongoing retention into care after the required time allotted to Service Linkage workers has expired. These challenges will be met by ongoing training and workforce development efforts. Additionally a strong follow up component will be added to the project so that referrals are followed up and receive appropriate care.

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

Goals from the Joint Comprehensive Plan:

1. Target linkage to care efforts to vulnerable points in the HIV system (e.g., at initial diagnosis, before the first medical visit, after the initial visit, etc.) where individuals are more likely to not seek care or to fall out of care, particularly newly-diagnosed Persons living with HIV or AIDS (PLWHA).

2. Intensify retention and engagement activities with currently in-care PLWHA, focusing on community education, system enhancements, and health literacy

3. Adopt strategies to re-engage out-of-care PLWHA and other “prior positives” to return to care

**Starting Point/Baseline:**

Baseline data on navigation program after implementation will be collected in Year 2 of the project.

**Rationale:**

HIV related hospitalizations account for a significant portion of national health care costs every year. Many of these visits occur when patients are not receiving continuous care to manage their infections. By increasing the number of newly diagnosed HIV positive patients who are linked to clinical care within three months, and increasing the number of patients who receive continuous clinical care, the number of HIV related hospitalizations can be greatly reduced, resulting in significant cost savings.

**Project Components:** This project will address all the components of a navigation program. Required core project components:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency. – We plan to work with hospital ED and
Expanded Testing Initiative (community based testing) to assist newly diagnosed HIV patients navigate through the health care system. Our navigators (service linkage workers) will be trained in cultural competency to reflect the diverse population in Houston.

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators. – Our navigators will use a non-medical case management model to address the needs to the patients.

c) Connecting patients to primary and preventive care - Our navigators will ensure that the patients are connected to primary and preventive care so that they are better equipped to manage their conditions with a specified time period after their diagnosis and entry into the Service Linkage Program..

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management – Our navigators will also provide information and instruction on chronic disease care and self management.

e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations - Our navigation program will conduct continuous quality improvements and share lessons learned.

Unique community need identification numbers the project addresses
The HIV Service Linkage Expansion Program also addresses the issues addressed in the following community needs assessments:

- CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including AIDS/HIV
- CN.23 Lack of patient navigation, patient and family education and information programs

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

This project is an expansion of an existing, federally funded HIV Service Linkage program. However, this project does not receive any federal funding. The project will add additional service linkage workers to serve a target population of HIV positive individuals who are on Medicaid or are indigent and are at risk from being disconnected from the health care system.

Related Category 3 Outcome Measures:

OD- 9 Right Care, Right Setting
IT-9.4 Other Outcome Improvement (ED Appropriate Use)
Numerator: Number of HIV patients that are in Service Linkage Program that were admitted to a hospital in the past 6 months.
Denominator: Total number of HIV patients enrolled in Service Linkage Program during the same time period.
Data Source: Service Linkage Database, Patient electronic records
Reasons/rationale for selecting the outcome measures:
We chose “Other Outcome Improvement” under Outcome Domain 9 (Right Care Right Setting) due to the high ED utilization for newly diagnosed HIV patients who may suffer from multiple comorbidities. Providing navigation services to HIV patients who are at high risk of disconnect from institutionalized health care is critical to reduce ED and inpatient use for potentially preventable admissions in HIV patients. The Houston Area has placed a high priority on ensuring early linkage into HIV clinical care and treatment for those newly diagnosed through widespread HIV testing and awareness efforts.

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

The ability to properly identify and monitor specific patients with chronic conditions or frequent emergency department utilization trends will allow the region to accurately manage the very large patient base. Patient navigation includes a comprehensive list of tasks as well as unique provider types based on the focus of the initiative and will help the focus of cost containment, emergency department utilization, and chronic disease management. The Region 3 Initiative Grid in the addendum allows for a cross reference of all initiatives proposed within this concept.

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

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

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The HIV Service Linkage Expansion received a composite Prioritization score of 6.5 and a Public Health Impact score of 6.
## Project Title: HIV Service Linkage Expansion Program

**Performing Provider Name:** City of Houston Department of Health and Human Services (HDHHS - 0937740-08)

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 1 [P – X1]: Plan scope, range, current capacity and needed resources for the Service Linkage Expansion Program.</td>
<td>Milestone 4 [P-3]: Provide care management/navigation services to targeted patients. Metric 1[P-3.1]: Increase in the number or percent of targeted patients enrolled in the program. Goal: Implement program as per plan. Data Source: Enrollment reports.</td>
<td>Milestone 7 [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1[I-6.4]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment. Goal: Increase PCP referrals by 5% over baseline (to 288 patients). Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program.</td>
<td>Milestone 8 [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1[I-6.4]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment. Goal: Increase PCP referrals by 10% over Baseline (to 303 patients). Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program.</td>
</tr>
<tr>
<td>Milestone 2 [P – 2]: Establish a health care navigation program to provide support to HIV populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. Metric 1[P-2.1]: Establish optimum number of people that should be trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators.</td>
<td>Milestone 4 Estimated Incentive Payment: $761,675.80</td>
<td>Milestone 7 Estimated Incentive Payment: $2,432,514.11</td>
<td>Milestone 7 Estimated Incentive Payment: $2,350,813.70</td>
</tr>
</tbody>
</table>

### Related Category 3 Outcome Measures:

| 0937740-08.3.6 | 2.9.1 | 2.9.1 (a-e) | IT-9.4 Milestone: ED appropriate utilization (Stand-alone measure) |

---

**Goal:** Provide report documenting all process measures listed above. Data Source: Program Documentation.

**Milestone 1 Estimated Incentive Payment:** $687,237.74

**Milestone 5 Estimated Incentive Payment:** $761,675.80

**Milestone 8 Estimated Incentive Payment:** $2,350,813.70

---

**Regional Healthcare Partnership Plan**

**Region 3**

982
<table>
<thead>
<tr>
<th>Year</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Milestone 6 [P-X3]: Establish baseline for number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services.</td>
<td>Metric 1 [P-X.3]: Collect data to determine number patients without a primary care provider who are given a scheduled primary care provider referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Goal: Workforce development plan for patient navigator recruitment, training and education. Goal: Provide report documenting workforce development for patient navigators (service linkage workers).</td>
<td>Goal: Establish baseline of 275 patients for connecting program enrollees to primary care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data Source: program Documentation</td>
<td>Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Milestone 2 Estimated Incentive Payment: $687,237.74</td>
<td>Milestone 3 Estimated Incentive Payment: $761,675.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Milestone 3 [P-X2]: Develop and test database created for HIV Service Linkage navigation program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Metric 1[P-X2.1]: Determine and provide documentation of type of system and IT resources needed. Metric 2[P-X2.2]: Select, install and test navigation data system. Goal: Database that has capacity for efficient reporting of project outcomes and processes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data Source: Program documentation Milestone 3 Estimated Incentive Payment: $687,237.74</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Year 2 Estimated Milestone Bundle Amount: $2,061,713.23</td>
<td>Year 3 Estimated Milestone Bundle Amount: $2,285,027.41</td>
<td>Year 4 Estimated Milestone Bundle Amount: $2,432,514.11</td>
<td>Year 5 Estimated Milestone Bundle Amount: $2,350,813.70</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**: $9,130,068.44 (add milestone bundles amounts over DYs 2-5)
**Project Option - 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (TB patients or suspected TB patients)**

**Unique Project ID:** 0937740-08.2.4

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

**Project Summary:** Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

Last year, a similar project with a smaller scope, utilizing just two testing modalities served 396 TB patients, of which 119 were completely uninsured. 103 of these were African Americans and 191 were White Hispanic. This project intends to serve 750 individuals in DY3, 788 individuals in DY 4 and 825 individuals in DY5 per year to improve TB outcomes.

**Intervention(s):** The performing provider will implement interventions to rapidly identify, treat and short recovery to reduce TB morbidity for TB patients, contacts of foreign born TB cases and suspected cases enrolled in this project by utilizing three testing and technology (Nucleic Amplification Test, QuantiFERON test and combined INH and RPT tests to meet its goals.

**Need for the Project:** This project provides a community level, comprehensive evidence based care to patients that have active or latent TB, and their contacts and suspects. The project will rapidly and accurately identify cases and provide a short term therapy that cuts down on number of days of hospital stay.

**Target Population:** The target population will be at risk vulnerable populations such as the homeless, chronically ill low income population, refugee and new immigrant population, indigent, those without access to care or without a medical home who are routinely reported to the performing provider for active or latent TB.

**Category 1 or 2 expected patient benefits:** Increase the number or percent of patients in defined population receiving innovative intervention at DY3 baseline total (230 individuals) consistent with evidence-based model by 5% over baseline in DY4 (242 individuals) and by 10% (254 individuals) over baseline in DY5. Estimated patient impact - DY3: NAAT - 50, 3HP - 80, QFT – 100; DY 4: NAAT - 53, 3HP - 84, QFT – 105; DY5: NAAT - 56, 3HP - 88, QFT - 110.
Category 3 outcomes: The two category 3 outcomes are 1) IT-4.10 Other Outcome Improvement Target: Average length of stay for patients diagnosed with TB. Decrease average length of stay by 2% in DY4 and by 5% over baseline in DY5. 2) IT-6.1 Increase in patient satisfaction scores for patients enrolled in program by 5% over baseline in DY4 and by 10% over baseline in DY5.

Project Option - 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations: Tuberculosis Rapid Identification, Treatment and Recovery Project

Unique Project ID: 0937740-08.2.4
Performing Provider Name/TPI: City of Houston Department of Health and Human Services /0937740-08

Project Description: The Tuberculosis Rapid Identification, Treatment and Recovery Project proposes to utilize three modalities of testing and treatment to reduce Tuberculosis morbidity in Houston. The three modalities are 1) Nucleic Acid Amplification Test for rapid identification of cases 2) QuantiFERON test for greater accuracy in identification of TB and 3) Combination INH and RPT Therapy for reducing the period of treatment to a 12 week directly observed therapy (DOT) instead of the previously used 9 month INH treatment. The project will utilize nurse case managers, community outreach workers, patient navigators and other partners to implement this project in the community. The program enrollees will be recruited from the reported cases due to mandatory reporting and their contacts. Additionally, health care providers and hospitals will be another venue for recruitment.

According to World Health Organization, economically poor and vulnerable populations, cultural/ethnic minorities, migrant populations, gypsies and travelers, homeless people and substance users are all at greater risk of Tuberculosis (TB) infection and disease and are likely to have worse treatment outcomes than the general population. Their complex needs are often overlooked and they experience barriers to access routine health care. Vulnerable populations such as the homeless, chronically ill low income population, those without access to care or without a medical home face the greatest burden of morbidity from Tuberculosis (TB). Among many vulnerable groups TB can be treatable and preventable with timely and accurate diagnosis and treatment. Studies have shown about 5 to 10 percent of those with latent TB infection in the United States will develop TB disease if not treated. People with latent TB infection who have weakened immune systems, including those with HIV/AIDS or diabetes, are more likely to develop TB disease after infection. For those reasons, treatment is important (3). These potential future TB cases could be admitted to hospitals for diagnoses and treatment resulting in significant costs to the healthcare system.

United States law requires that anyone with active TB must be reported to the health department. The Health Department staff is required to work with the patient's healthcare provider and the patient to make sure that a safe and effective treatment regimen is completed. This project will expand the performing provider’s (Houston Health and Human Services) capacity to serve TB patients and contacts, through the addition of trained TB outreach and nurse case management specialists. The project will proactively engage patients and providers in TB case management. This Project proposes to utilize patient navigators to rapidly identify active
TB cases, infectious cases and more accurately screen contacts for TB infection, and reduce the length of treatment through the introduction of short course therapy.

Utilizing the CDC guidelines and the Texas Department of State Health Services Tuberculosis Branch standing delegation orders, the Performing Provider, Houston TB Bureau, will implement the use of 3HP in the treatment latent tuberculosis patients in order to increase patient compliance and completion of therapy and decrease the number of patient at risk for progression to active TB disease. The project replaces the existing system (protocol) of testing to diagnose TB disease with a quicker more reliable method.

The Houston TB Bureau will adopt cost-effective diagnostic and treatment approaches. Program Nurse case managers will engage in collaboration with medical providers and hospital infection control staff to recommend the use of the nucleic acid amplification test on bacteriology specimens. The nurse case managers will also provide education and consultations and will recommend for bacteriology specimens to be processed at the HDHHS laboratory.

The following sections provide additional details on the testing modalities that will be used:

**Nucleic Acid Amplification Test:** The use of nucleic acid amplification test (NAAT) will assist in the rapid identification of active TB disease in patients with positive bacteriology acid fast bacilli (AFB) smears within 72 hours, compared to the traditional culture that takes up to six to eight weeks. The result of this test will guide the physician’s treatment plan, including the use of medications. The use of NAAT at the program level will ensure more effective contact investigation by curtailing the number of unwarranted contact investigations. Also, the use of NAAT will assist the hospitals in making the decision to move patients from more expensive isolation rooms to possible outpatient treatment. The anticipated patient length of stay at a hospital is 1-14 days; difficult cases with multiple health conditions may require up to 60 days, the average length of time for contagious TB clients to convert, as reported by the Texas Department of Infectious Disease in San Antonio.

Furthermore, outpatient treatment of tuberculosis is more cost effective since the main determinant of cost in treating TB is hospital stay. If a patient is already admitted when the diagnosis of TB is made, it may not be necessary to keep the patient in the hospital while waiting for sputum to convert to negative. Smear/culture positive patients may be discharged from the hospital as long as certain criteria are met. The Houston Health and Human Services (HDHHS) laboratory will be available to perform the NAAT on the specimens collected for rapid identification of possible TB disease.

**QuantiFERON test:** The use of the QuantiFERON test will provide a more accurate screening for TB infection by decreasing the number of patients with “false positive” results who would need evaluation. The QFT has been found to be more specific and sensitive than the traditional tuberculin skin test (TST). Patients identified through contact investigation (beginning with the foreign born and individuals in congregate settings) will be screened using the QFT. The implementation of QFT-G in the field will reduce the costs associated with clinic visits by individuals who are not truly positive reactor (including costs for doctor visits, chest X-rays and medications). QFT-G requires a single visit to complete the testing process for TB infection. TST requires two or more visits to complete the testing process. The initial targeted population for QFT-G test would be those who live in congregate settings; including homeless shelters and drug...
rehabilitation centers. As the project progresses, the use of this test can be expanded to include foreign born individuals and household contacts.

Community outreach workers in the field will perform the QuantiFERON test on persons identified as contacts to patients with active tuberculosis or suspected of having tuberculosis. The outreach staff will transport the blood specimens to the HDHHS laboratory. The HDHHS laboratory will provide results to the TB Bureau. The community outreach workers will notify the patients of the results and will coordinate medical follow up as needed.

Nurse Case Managers will communicate with providers the benefits of prescribing a new two-drug short course treatment to patients with latent tuberculosis infection. The nurse case managers will also provide education and consultations. The short course treatment will be provided by community outreach workers in the field through directly observed therapy (DOT).

**Combination INH and RPT:** A new two-drug short course regimen treatment for contacts identified as needing treatment for latent TB infection (LTBI) will be used in the field. This new two-drug regimen (3HP, Isoniazid and Rifapentine) is recommended by the Centers for Disease Control and Prevention (CDC). The combination regimen of INH and RPT given as 12 weekly DOT doses is recommended as an equal alternative to 9 months of daily self-supervised INH for treating LTBI in otherwise healthy patients aged ≥12 years who have a predictive factor for greater likelihood of TB developing, which includes recent exposure to contagious TB, conversion from negative to positive on an indirect test for infection (i.e., interferon-γ release assay or tuberculin skin test), and radiographic findings of healed pulmonary TB (see Precautions). HIV-infected patients who are otherwise healthy and are not taking antiretroviral medications also are included in this category (2).

The implementation of this short course regimen (3HP) is to be provided via directly observed therapy (DOT) in the field for a course of 12-16 weeks as opposed to the traditional therapy of 9 months of Isoniazid. The 3HP will be used for treatment of LTBI to foreign born contacts, HIV-infected patients not on antiretroviral and difficult to manage contacts.

The nurse case managers will engage in collaboration with medical providers and hospital infection control staff to recommend the use of the nucleic acid amplification test on bacteriology specimens and the short course treatment (3HP). The nurse case managers will also provide education and consultations.

**Target Zip Codes:**
This program is city wide in Houston, Texas.

**Goals and Relationship to Regional Goals:**
This project seeks to utilize the NAAT, QFT and 3HP and a combination of nurse case managers and community outreach workers to provide comprehensive integrated care for TB patients, in order to reduce the number of days of hospitalization for those with TB and those with latent TB.

**Project Goals:**
- To accurately and rapidly identify and rule out TB disease
- To work collaboratively with providers in hospitals and communities to diagnose and manage more patients with TB through the program the performing provider will:
  - Rapidly and accurately identify cases
  - Partner with other healthcare providers and navigate patients to appropriate care
  - To decrease the number of days a patient will need to stay in isolation room
  - To decrease the number of contacts needing medical evaluation and medications
To increase the number of contacts completing treatment for LTBI, thus decreasing the number of future cases.

This project meets the following regional goals:

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

Challenges:

The challenges that the performing provider expects are related to information dissemination, buy-in from patients and providers, training staff on new treatment management and testing technique, working with chosen provider who will perform an increased volume of laboratory testing, training in phlebotomy techniques, and finally effectively promoting the program. Continuous effort will be made to provide required in service and training to program staff so that they are better equipped to handle issues as they arise. The TB Bureau will utilize nurse case managers to promote the use of NAAT and 3HP among providers and hospital settings.

5-Year Expected Outcome for Provider and Patients:

The performing provider expects that the overall health outcomes will improve for those with TB (active, latent and at-risk) who are served by the program in Houston. There is cost savings to the health care system though rapid identification, reduced hospital stays, fewer medical procedures, and fewer false positives.

Starting Point/Baseline:

Baseline data will be collected during Year 2-3 of the program.

Rationale:

The implementation of QFT-G in the field will reduce the costs associated with clinic visits by individuals who are not truly a positive reactor (including costs for doctor visits, chest x-rays and medications). QFT-G requires a single visit to complete the testing process for TB infection. TST requires two or more visits to complete the testing process. The initial targeted population for QFT-G test would be those who live in congregate settings; including homeless shelters and drug rehabilitation centers. As the project progresses, the use of this test can be expanded to include foreign born individuals and household contacts.

This new two-drug regimen (3HP, Isoniazid and Rifapentine) is recommended by the Centers for Disease Control and Prevention (CDC). The combination regimen of INH and RPT given as 12 weekly DOT doses is recommended as an equal alternative to 9 months of daily self-supervised INH for treating LTBI in otherwise healthy patients aged ≥12 years.

Project Components:

This project option does not have any specified components. However, this project will have built in quality improvement strategies such as lessons learned, participation in continuous quality improvement and utilizing the PDSA process to make quality improvements (QI). The performing provider will refine protocol and processes by making improvements based on the initial batch of enrollment into the program. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring,
and evaluating performance to improve desired outcomes. The QI activities will continue on an ongoing basis to assure that the intervention is being delivered with high integrity. Some elements of the program are new and some aspects are an expansion on existing program components and QI activities with incremental improvements will be put in place for both components.

Unique community need identification numbers the project addresses:

- CN.6 - Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly. 4, 5
- CN.20 - Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, and patient education programs. 4,5

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

The project provides comprehensive care to TB patients that have active or latent TB. This project will implement a comprehensive evidence based disease prevention program by rapid testing, accurate diagnosis and reduced treatment time for patients diagnosed with TB. The project staff will be trained to approach patients in a culturally appropriate manner. Additionally, the implementation of the new short form therapy protocol is new to the management of TB disease for the program.

Related Category 3 Outcome Measures:
IT-4.10 Other Outcome Improvement Target – Reduce number of days of hospitalization of TB patients

Reasons/rationale for the selecting the outcome measures:

We selected the above outcome measure because the goal of this program is to reduce hospital stays through a comprehensive diagnosis and treatment strategy. According to HCUP, in 2006 TB-related hospital stays accounted for $752 million in hospital costs, and Medicaid covered 24.4 percent of all TB stays. Hospital stays principally for TB had an average cost of $20,100 and an average length of stay of 15 days—more than twice the cost and three times the length of the average non-maternal, non-neonatal stay (HCUP, 2008). Therefore, our outcome measures of reduced hospital admissions for TB are appropriate because of the savings to the healthcare system.

Relationship to Other Projects and Plan for Learning Collaborative:

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

The ability to properly identify and monitor specific patients with chronic conditions or frequent emergency department utilization trends will allow the region to accurately manage the very...
large patient base. Patient navigation includes a comprehensive list of tasks as well as unique provider types based on the focus of the initiative and will help the focus of cost containment, emergency department utilization, and chronic disease management. The Region 3 Initiative Grid in the addendum allows for a cross reference of all initiatives proposed within this concept.

**Project Valuation:**

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

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

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The TB Rapid Identification, Treatment and Recovery Project received a composite Prioritization score of 7.15 and a Public Health Impact score of 7.

References:

4. Stakeholder input from RHP 3Working Group Members throughout the Region (including providers, consumers, hospital and clinic administrators, government officials, researchers, and advocacy groups)

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1** [P – X1]: Plan, scope, range, current capacity and needed resources for the TB Program.

**Metric 1** [P-X1.1]: TB Program Planning Materials, Meeting minutes, Sign-in sheets, Staff Qualifications, Staffing Plan

Goal: Provide report documenting all process measures listed above

Data Source: Program Documentation

Milestone 1 Estimated Incentive Payment: $748,692.81

**Milestone 2** [P – 1]: Development of innovative evidence-based project for targeted population.

**Metric 1** [P-1.1]: Document innovational strategy and plan

Goal: Develop project to reduce morbidity in target population.

Data Source: Program Documentation

Milestone 2 Estimated Incentive Payment: $748,692.81

**Milestone 3** [P-4]: Execution of

Milestone 4 [P-2]: Implement evidence-based innovational project for targeted population

**Metric 1** [P-2.1]: Document implementation strategy and testing outcomes.

Goal: Implement program as per plan

Data Source: Documentation of implementation and Enrollment reports

Milestone 4 Estimated Incentive Payment: $829,787.37

**Milestone 5** [P-3]: Execution of learning and diffusion strategy for testing, spread and sustainability.

**Metric 1** [P-3.1]: Document learning and diffusion plan

Goal: Establish strategies for rapid spread of awareness of innovation

Data Source: Program documentation of implementation

Milestone 5 Estimated Incentive Payment: $829,787.37

**Milestone 6** [I-5]: Identify number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model.

**Metric 1** [I-5.1]: Increase the number of individuals receiving the innovative interventions.

Goal: Increase proportion of individuals receiving interventions by 5% over baseline (established in Yr 3). The number of patients served in DY4 will be 242.

Data Source: Documentation of target population reached, as designated in the project plan.

Milestone 6 Estimated Incentive Payment: $883,345.85

**Milestone 7** [I-5]: Identify number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model.

**Metric 1** [I-5.1]: Increase the number of individuals receiving the innovative interventions.

Goal: Increase proportion of individuals receiving interventions by 10% over baseline (established in Yr 3). The number of patients served in DY5 will be 254.

Data Source: Documentation of target population reached, as designated in the project plan.

Milestone 7 Estimated Incentive Payment: $1,280,515.61

**Milestone 8** [P-X2]: Identify number of hospitals utilizing innovative intervention consistent with evidence-based model.

**Metric 1** [P-X2.1]: Document the number of Hospitals utilizing the

**Milestone 9** [I-X1]: Identify number of hospitals utilizing innovative intervention consistent with evidence-based model.

**Metric 1** [I-X1.1]: Increase the number of Hospitals utilizing the

**Milestone 10** [I-X1]: Identify number of hospitals utilizing innovative intervention consistent with evidence-based model.

**Metric 1** [I-X1.1]: Increase the number of Hospitals utilizing the

**Milestone 11** [I-X1]: Identify number of hospitals utilizing innovative intervention consistent with evidence-based model.

**Metric 1** [I-X1.1]: Increase the number of Hospitals utilizing the
**0937740-08.2.4**

<table>
<thead>
<tr>
<th>Performing Provider Name: Houston Department of Health and Human Services</th>
<th>HDHHS -0937740-08.2.4</th>
</tr>
</thead>
</table>

### Related Category 3 Outcome Measures:

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**P-4.1. Metric:** Document evaluative process, tools and analytics.

- **a.** Data Source: Performing Provider contract or other documentation of implementation TBD by Performing Provider
- **b.** Goal: Evaluation of project in a systematic way to improve and account for public health actions.

**Milestone 3 Estimated Incentive Payment:** $748,692.81

**percent of patients in defined population receiving innovative intervention consistent with evidence-based model.**

**Metric 1 [I-5.1]: TBD by Performing Provider based on milestone described above**

Baseline: Establish Baseline of 230 individuals receiving innovative intervention.

- **Data Source:** Documentation of target population reached, as designated in the project plan

**Milestone 6 Estimated Incentive Payment:** $829,787.37

**innovative interventions.**

Baseline: Establish the baseline number of hospitals utilizing innovative interventions

- **Data Source:** Documentation of target population reached, as designated in the project plan

**Milestone 8 Estimated Incentive Payment:** $883,345.85

**Milestone 9 [I-X1]: Increase number of hospitals utilizing innovative intervention consistent with evidence-based model.**

Metric 1 [I-X1.1]: Increase the number of Hospitals utilizing the innovative interventions.

- **Goal:** Increase the number of hospitals utilizing innovative interventions by 3 % over baseline

- **Data Source:** Documentation of target population reached, as designated in the project plan

**Milestone 9 Estimated Incentive Payment:** $1,280,515.61

**Goal: Increase the number of hospitals utilizing innovative interventions by 10% over baseline**

- **c.** Data Source: Documentation of target population reached, as designated in the project plan

**Milestone 11 Estimated Incentive Payment:** $1,280,515.61
<table>
<thead>
<tr>
<th>0937740-08.2.4</th>
<th>2.71</th>
<th>2.7.1</th>
<th>TB RAPID IDENTIFICATION, TREATMENT AND RECOVERY PROJECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing Provider Name: Houston Department of Health and Human Services</td>
<td>HDHHS -0937740-08.2.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Related Category3 Outcome Measures:</strong></td>
<td>0937740-08.3.7</td>
<td>IT-4.10</td>
<td>Other Outcome Improvement Target</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $2,246,078.44</td>
<td>Year 3 Estimated Outcome Amount: $2,489,362.10</td>
<td>Year 4 Estimated Outcome Amount: $2,650,037.55</td>
<td>Year 5 Estimated Outcome Amount: $2,561,031.22</td>
</tr>
<tr>
<td>Payment: $883,345.85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add milestone bundles amounts over DYs 2-5): $9,946,509.31</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Project Option 2.2.6 - Expand Chronic Care Management Models “Other” project option

Unique Project ID: 0937740-08.2.5

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

Project Summary:

Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs.

Intervention(s): The Diabetes Awareness and Wellness Network (DAWN) Center is a new initiative serving 400 participants at baseline (75 diagnosed diabetics, 125 with pre-diabetes glucose levels and 200 community members at risk for diabetes) per year from DY 3-5. The Center will provide complementary wellness programming and offer prevention and intervention services and coordination of care for those with diabetes or at risk for diabetes through enhanced education, physical activity, self-management education, hemoglobin A1C tracking and monitoring, BMI measurements, behavioral change coaching, and case management. Participants will be recruited from 3 FQHC’s, County Hospital based diabetes center and one dialysis center that all serve low income Medicaid patients.

Need for the Project: Comprehensive disease management can reduce costs based on less hospitalizations, decrease in loss of productivity, decrease in absenteeism, and decrease in unemployment from disease-related disability. Diabetes patients or those at risk for diabetes receive the greatest benefit from disease management or health enhancing behaviors to lower their risks to develop diabetes.

Target Population: Individuals with diabetes or at risk for diabetes residing in an underserved area (Third Ward) with a high incidence of diabetes will benefit from the comprehensive wellness program.

Category 1 or 2 expected patient benefits: Increase proportion of patients with disease self-management goals in the DAWN Center by 5% over baseline in DY 4 and by 10% over baseline in DY 5. The baseline year will serve a target of 200 (diagnosed diabetics and pre-diabetics), in DY 4 the Center will serve 210 new diabetics and pre-diabetics and in DY 5 the Center will serve 220 new diagnosed diabetics and pre-diabetics that have disease self-management goals. The DAWN Center itself will serve an 200 additional community members/year (in addition to the
pre-diabetic and diabetic patients) that are deemed to be at risk for developing diabetes (identified through the American Diabetes Association risk assessment tool).

Category 3 outcomes: IT-1.10 Diabetes care: Decrease proportion of patients with HbA1c poor control by 2% over baseline in Wellness Center enrollees in DY4 and IT-1.10 Diabetes care: Decrease HbA1c poor control by 5% over baseline in DAWN enrollees in DY5.

Project Option 2.2.6 -Expand Chronic Care Management Models “Other”: DAWN Center

**Unique Project ID:** 0937740-08.2.5  
**Performing Provider Name/TPI:** City of Houston Health and Human Services / 0937740-08

**Project Description:**  
*This project would establish a comprehensive, community based Diabetes Wellness Center in an underserved community with one of the highest incidence rates of diabetes*

The Diabetes Awareness and Wellness Network (DAWN) Center will provide complementary wellness programming and offer prevention and intervention services and coordination of care for those with diabetes and other chronic conditions. The process and improvement targets have been chosen based on the project goals of chronic care self-management, care transitions, self-management goal setting, and a community based coordinated system of care. The DAWN center will be located in the Third Ward community in Houston in Council District D.

The DAWN Center will consist of four distinct but interrelated components:

1) **Active Living and Healthy Eating Campaign**  
The campaign will focus on promoting healthy lifestyles such as active living and healthy eating through policy and environmental change strategies using appropriate strategies in a previously identified geographically targeted population. Campaigns currently exist which promote an individual’s responsibility for their health; this new campaign would expand that message to promote the understanding of how environments and livability impact health and the role individuals can take to improve their health (social-ecological model).

2) **Enhanced Education and Self-Management**  
The Enhanced Education and Self-Management Component will includes complementary wellness programming in existing facilities located in an identified geographically targeted area most at risk of debilitating chronic disease outcomes. This component incorporates evidence-based behavior supports such as Stanford’s Diabetes Self-Management Program\(^1\) and Merck’s Diabetes Conversation Maps,\(^2\) with monitored fitness rooms and interventions, nutrition education and produce programs as well as care coordination to ensure access to and utilization of primary health care. These activities are coupled with clinical screenings and referrals, medication management coaching and telephonic follow-up to improve quality of life and reduce the incidence of hospitalization.

---


3) Geographically Targeted Registry Pilot
Clinical surveillance techniques have historically been used to study infectious diseases. Databases have been created to monitor HIV/STD/influenza/SARS outbreaks. Registries have now also been developed for cancer as a way to monitor incidence and determine prevalence and possible causes. As diabetes approaches epidemic proportions, there is an increasing interest in disease registries for various chronic diseases, but particularly for diabetes. The implementation of a geographically targeted registry pilot will include tracking the individual hemoglobin levels and diagnosis codes reported by clinical laboratories serving the targeted population. Collecting the hemoglobin A1C test results and compiling the results submitted would allow HDHHS to track:

1. The prevalence of diabetes among people tested in the targeted population
2. Level of control by people with diabetes within various demographic groups in the area
3. Trends for new diagnoses of diabetes in the area
4. Estimated health care costs associated with diabetes and testing. The results could also be used for conducting cost-benefit analyses for seeking research, prevention and education funding. Ultimately, results would be used to determine the best interventions for implementation for the targeted populations.

4) Care Transition
It is statistically likely that the DAWN participants will be at high risk of preventable hospitalization. DAWN will utilize the Coleman Model for Care Transition (http://www.caretransitions.org) to guide interdisciplinary work to avoid preventable hospitalizations through a liaison relationship with three hospitals that frequently serve the target population. During the four-week Care Transitions program, patients with complex care needs and family caregivers work with a “Transition Coach” and learn self-management skills that will ease their transition from hospital to home. The coach is a licensed staff person (social worker or nurse) who has received training in the Care Transitions Intervention program. This intervention is centered on four pillars: 1. Medication self-management; 2. The Personal Health Record; 3. Timely primary care/specialty care follow up; and 4. Knowledge of red flags that indicate a worsening in their condition and how to respond. The DAWN Care Transition Coach will provide family education on preventable hospitalizations and assist in training community-based resources that can assist individuals with limited family support.

Goals and Relationship to Regional Goals:
The overall goal of this program is to empower people to make lifestyle changes to stay healthy and self-manage their chronic conditions.

Project goals:
1. Promote health behavior change and improve overall quality of life
2. Reduce risk for progressive disease impacts;
3. Increase healthy disease management behaviors;
4. Build natural (individual) supports for health maintenance;
5. Monitor and assess effective intervention for subpopulations impacted by diabetes;
6. Reduce Potentially Preventable Admissions/Readmissions (PPA/PPR)

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

Challenges:
In developing the Active Living and Healthy Eating Campaign, two challenges that we anticipate are the development of messages that resonate with diverse community populations and the determination of the most appropriate channels of communication. To overcome these challenges we will work in partnership with a group of community based organizations that serve the diverse populations that will be utilizing the Center. We will conduct focus groups and use the results to develop messages and select appropriate channels of communication. A second challenge is the development of an electronic records system to reflect progress on behavior change program goals. This challenge will be met by meeting with other entities that have faced a similar challenge and learning from them. Two challenges anticipated through the geographically-targeted registry pilot include “getting buy-in from providers” and determining whether to make the registry mandatory or voluntary. Getting buy-in from providers will be accomplished by providing an orientation and tour for providers. Providers will then know that the DAWN Center wants to partner with them to provide services that they cannot provide and at a location that is convenient for the patient. The challenge with the registry has to do with whether or not the Center wants to provide an “opt out” option to participants. The Center staff will work with participants to assure them that the registry will allow the Center to track progress and provide alternative activities for the successful management of their diabetes. In order to make “care transition” successful, the development of liaison relationships with key hospitals and providing home-based care for clients with limited family support will be key. These challenges will be met by working with the Area Agency on Aging (AAA, housed within the Houston Health Department) in the area of training. AAA has run a similar program and has learned how to work with hospitals and clients with limited family support.

5-Year Expected Outcome for Provider and Patients:
HDHHS expects to see improved self-management of diabetes by patients served at the DAWN center. Additionally there is an expected avoidance of preventable hospital admissions for patients with diabetes who are served by the center.

Starting Point/Baseline:
Baseline data for the project will be established by the end of the first year of program implementation (DY3).

Rationale:
A review of literature (Economic Costs of Diabetes in the U.S. in 2007) indicates that a program similar to the Diabetes Awareness and Wellness Network (DAWN) Center that focuses on enhanced education, physical activity, self-management education, hemoglobin A1C tracking and monitoring, BMI measurements, behavioral change coaching, and case management can
reduce costs based on less hospitalizations, decrease in loss of productivity, decrease in absenteeism, and decrease in unemployment from disease-related disability (www.ncbi.nlm.nih.gov/pubmed/18308683).

The prevalence of Diabetes in Greater Third Ward-Macgregor-Gulfgate area of City of Houston, where the DAWN Center will be based has a high prevalence of diabetes. This area is one of the 28 geographic units within Harris County used by Houston Health Survey 2010. As per Census 2010 data, Blacks represent more than half (52.78%) of the total population residing in this area. Similarly, 35.39% of the population is Hispanics. Almost 40% of the total population living in the area is 40 years and older.

Overall, in the U.S. diabetes prevalence rate is almost twice among Blacks and Hispanics compared to Non-Hispanic whites. Similarly, educational attainment among the residents-a proxy measure of overall health of the community- is low in the proposed area. For example, percentage of residents with less than a high school degree among 25 years or older was 31 compared to 21% in Houston (3). Similarly percentage of residents (18 years and older) with household income less than 100% of federal poverty level in the proposed area is 39%, a higher rate compared to Houston as a whole (26%). According to Houston Health Survey (2010), the unemployment rate among adults (18 years +) was 22%, higher than Houston average of 16%. Other indicators of health such as percentage of population reporting 7 or more days of poor physical health in the past month was higher among the residents of the proposed area compared to Houston average. Higher rates of obesity was reported in the proposed area (34%) compared to Houston average of 30%. Diabetes diagnosis was also slightly higher than the Houston average, 12% vs. 11% respectively (1).

As per the Houston Health Survey (2010), described in the previous page, diabetes diagnosis in Harris County is 9.5% among Non-Hispanic Whites, 15.2% among Non-Hispanic Blacks, 11% among Hispanics and 5.8% among Asians. Among all races, the prevalence is 11.1%. Among Non-Hispanic Blacks, women have higher rates (17.3%) than the men (12%).

On the HCUP website, some “outcomes/effectiveness research” reports indicated that better adherence to diabetes medications means fewer hospitalizations and emergency department visits. The researchers used a database containing information on 5 million individuals covered by employer-sponsored health insurance and included prescription drug insurance claims, employer health plans, hospitalizations, and ED visits. The final sample consisted of 56,744 individuals with Type 2 diabetes, who required oral anti-diabetic medications to manage their condition. When adherence rates were raised from 50% to 100%, although diabetic drug costs increased substantially; for payers, this still resulted in a savings of $1.12 in hospital care for every dollar that was spent on diabetes medications. When reduced ER costs were taken into consideration, a total cost savings of $1.14 for every additional dollar spent on medications were realized.


**Project Components:**
This project option does not have any required core components.
However, the DAWN project will include a component to conduct systematic quality improvement for the project.
Activities will include Identifying project impacts, “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion of the project, including special considerations for safety-net populations. Due to the performing provider’s experience and established networks in serving low income population in the County, this program will benefit from these experiences. Nevertheless, program processes will be refined and improved through a Plan-Do-Check-Act process. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes. It is expected that revisions to the protocol, training requirements, partnership processes and expectations will need to be clarified on a regular basis. These program components will be improved through the PDSA process. Initial program enrollment of a small number of target population in DY3 will help iron out the program weaknesses and allow for a continuous improvement process.

**Unique community need identification numbers the project addresses:**
The DAWN Center also addresses the issues addressed in the following community needs assessments:
- CN.1 Inadequate access to primary care
- CN.8 High rates of inappropriate emergency department utilization
- CN.10 High rates of preventable hospital admissions
- CN.20 Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
- CN.23 Lack of patient navigation, patient and family education and information programs.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
DAWN is a new initiative which places a comprehensive health and wellness center in a targeted community at risk for poor health outcomes.

**Related Category 3 Outcome Measures:**
OD-1 Primary Care and Chronic Disease Outcomes:
IT-1.10 Diabetes care: HbA1c poor control (>9.0%)17- NQF 0059 (Stand-alone measure)
- a Numerator: Percentage of patients 18-75 years of age with diabetes (Type 1 or Type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
- b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (Type 1 and Type 2)

**Reasons/rationale for the selecting the outcome measures:**
We chose this Outcome Measure because the DAWN Center aims to reduce prevalence and promote management of Diabetes in a high risk area. One of the most important indicators of blood sugar control is HbA1c. Clinically healthy range for HbA1c is less than 5.7%, values between 5.7% and 6.4% are considered pre-diabetes and values higher than 6.4 are referred to as diabetes. For a diabetic patient, it is recommended to maintain the HbA1C level below 6.5-7 %
HbA1C indicates how well one is controlling the blood sugar over the last 60-90 days, which helps the patients and their care providers to adjust the diet, physical activity and medication accordingly. HbA1C is also considered as the ‘gateway’ to care for individuals with type-2 diabetes.

According to the *Houston Hospitalizations at a Glance Report*, chronic conditions accounted for 78% of all adult preventable hospitalizations in Houston, with 26% of those being related to diabetes. This same report indicates that in Council District D, (most consistent with the targeted service area of the DAWN Center) the annual average cost of adult preventable hospitalizations for District D is $69,644,160 (the highest annual average cost for any District). Additionally, 22% of adult preventable hospitalizations in District D are diabetes-related. City Council District D has the second highest number of preventable diabetes hospitalizations (2,420). It also has the highest average cost per discharge of adult preventable hospitalizations by Council District ($32,038). Additionally, the literature ([Economic Costs of Diabetes in the U.S. in 2007, Diabetes Care31: 596-615, 2008](#)) indicates that a program similar to the Diabetes Awareness and Wellness Network (DAWN) Center that focuses on enhanced education, physical activity, self-management education, hemoglobin A1C tracking and monitoring, BMI measurements, behavioral change coaching, and case management can reduce costs based on less hospitalizations, decrease in loss of productivity, decrease in absenteeism, and decrease in unemployment from disease-related disability.

**Relationship to Projects and Plan for Learning Collaborative:**

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

Healthcare treatment cannot focus to only the acute or chronic encounter and properly treat the patient. It is critical that our region focuses on patient education and community education to ensure a proactive and responsive approach to healthcare needs. The education models represented in the Region 3 RHP plan can be identified in the Initiative Grid (addendum) and all focus to outcome measures such as appropriate utilization, patient satisfaction scores, and standalone chronic condition scores such as diabetes and asthma.

**Project Valuation:**

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

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening...
or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category. HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. DAWN received a composite Prioritization score of 7.10 and a Public Health Impact score of 7.
<table>
<thead>
<tr>
<th>Milestone 1 [P -X1]:</th>
<th>Milestone 3 [P-11]:</th>
<th>Milestone 5 [I-18]:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan scope, range, current capacity and needed resources for DAWN Center.</td>
<td>Develop and implement program to assist patient to better self-manage their chronic conditions (Diabetes)</td>
<td>Improve the percentage of patients with self-management goals (DY 4- from 200 to 210)</td>
</tr>
<tr>
<td><strong>Metric 1</strong>: DAWN Program Planning Materials, Meeting minutes, Sign-in sheets, Logic Model, Draft Clinical Protocols, Staff Qualifications, Staffing Plan. Goal: Produce a comprehensive document identifying results of planning and including information listed above.</td>
<td><strong>Metric 1</strong>: Increase the number of patients enrolled in a Diabetes self-management program. Goal: Implementation of DAWN programs. Numerator: Number of patients enrolled in a Diabetes self-management program for a given chronic condition. Denominator: Number of patients with given chronic condition enrolled in DAWN Center. Data source: EHR, DAWN Program documentation, class enrollment and attendance records.</td>
<td><strong>Metric 1</strong>: Patients with self-management goals. Goal: Increase by 5% over baseline the proportion of patients with self-management goals in DAWN Center. (Baseline to be achieved in Yr3 of 200 new diabetics and pre-diabetics) In DY 4, 210 new diabetics and pre-diabetics will have self-management goals. Data Source: Registry of DAWN.</td>
</tr>
<tr>
<td>Milestone 3 Estimate Amount: $1,123,092.70</td>
<td>Milestone 4 [P-13]: Develop and implement program for diabetes care managers to support primary care clinics.</td>
<td>Milestone 5 Estimate Amount: $1,325,081.88</td>
</tr>
<tr>
<td><strong>Metric 1</strong>: [P-13.1]: Diabetes care</td>
<td><strong>Metric 1</strong>: [I-18.1]: Patients with self-management goals. Goal: Increase by 10% over baseline the proportion of patients with self-management goals in DAWN Center. In DY 5, 220 new diabetics and pre-diabetics will have self-management goals. Data Source: Registry of DAWN.</td>
<td></td>
</tr>
<tr>
<td>Milestone 7 [I-18]: Improve the percentage of patients with self-management goals (DY 5 - Reach 220 patients with self-management goals)</td>
<td><strong>Metric 1</strong>: [I-18.1]: Patients with self-management goals. Goal: Increase by 10% over baseline the proportion of patients with self-management goals in DAWN Center. In DY 5, 220 new diabetics and pre-diabetics will have self-management goals. Data Source: Registry of DAWN.</td>
<td></td>
</tr>
<tr>
<td>Milestone 7 Estimate Amount: $1,280,576.60</td>
<td>Milestone 8 [I-21]: Improvements in access to care of patients receiving chronic care management services.</td>
<td>Milestone 8 [I-21]: Improvements in access to care of patients receiving chronic care management services.</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measures:</td>
<td>0937740-08.3.8</td>
<td>IT-1.10</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-----------------</td>
<td>---------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Milestone 2 Estimate Amount: $1,123,092.70</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal: Documentation and implementation of plan</td>
<td></td>
</tr>
<tr>
<td>Data source: Evidence of diabetes management care coordination clinic plan in target area</td>
<td></td>
</tr>
<tr>
<td>Milestone 4 Estimate Amount: $1,244,740.33</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Milestone 6 [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [I-21.2]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Increase by 5% over baseline (Baseline established in Yr 3) Total number of unique patients encountered in the clinic for reporting period. Data Source: DAWN Registry, EHR, Program Documentation</td>
<td></td>
</tr>
<tr>
<td>Milestone 8 Estimate Amount: $1,280,576.60</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $2,246,185.41</td>
<td>Year 3 Estimated Milestone Bundle Amount: $2,489,480.66</td>
</tr>
<tr>
<td>Year 4 Estimated Milestone Bundle Amount: $2,650,163.76</td>
<td>Year 5 Estimated Milestone Bundle Amount: $2,561,153.19</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5): $9,946,983.02*
Project Option 2.13.2 - Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner.

**Unique Project ID:** 0937740-08.2.6

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

**Project Summary:** Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

**Intervention(s):** The performing provider will conduct monitoring, screening, assessment, service plan development and linking participants to care (if willing) for a maximum of individuals (N=8000/year) and a minimum of N=6000/year, who frequently display a range of mental and physical symptoms that indicate alcohol or other substance abuse in DY4-5.

**Need for the Project:** The new Sobering Center initiative provides a short term facility where individuals arrested for being under the influence of alcohol or other substances need a facility where they are under medical supervision but not utilizing valuable health care resources at other settings such as hospitals admissions or the ER.

**Target Population:** The target population will be individuals that have been arrested by the Police Department for alcohol or other substance abuse issues and are taken to the Sobering Center. More than 75% are indigent, on Medicaid or homeless.

**Category 1 or 2 expected patient benefits:** 5% decrease over baseline in preventable admissions and readmissions into Criminal Justice System of those who were previously arrested for public intoxication and have participated in Sobering Center program in past 6 months in DY4 and 7% decrease over baseline in DY5. In DY3, it is expected that a baseline will be established of serving 500 contacts/month or 6000 contacts per year will be established when Center is operating fully. In DY4, this will decrease to 475 contacts/month and in DY5 it will decrease further by 7% from baseline to 465 contacts/month.

**Category 3 outcomes:** IT-9.4 Other: Decrease preventable admissions to ER/ hospitals/criminal justice setting due to non-emergent alcohol/other substance use intoxication in a 6 month period by 2% over baseline in DY4 and by 4% in DY5.
Project Option 2.13.2 - Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner: Sobering Center

Unique Project ID: 0937740-08.2.6

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

Project Description:
Texas’s mental health system provides rehabilitative services and pharmacotherapy to people with certain severe psychiatric diagnoses and functional limitations, but can serve only a fraction of the medically indigent population. It does not serve other high risk behavioral health populations and does not provide the range of services needed to deal with complex psychiatric, addiction and physical needs. These complex populations become frequent users of local public health systems. Each year, the Houston Police Department arrests and incarcerates over 17,000 individuals for Public Intoxication. The City of Houston Sobering Center will be an alternative means of handling public inebriates rather than constantly subjecting them to placement in an emergency room or a jail facility. The Sobering Center will offer a continuum of care using a comprehensive multidisciplinary approach for intoxicated persons brought to the Emergency Department as well as picked up by the Police Department from other public locations in the city. The Center is loosely modeled after the McMillan Stabilization Project in San Francisco and the San Diego Serial Inebriate Program. The Center will offer a range of services for individuals who frequently display a range of mental and physical symptoms that indicate alcohol addiction. The primary services that will be offered are:

1) Monitoring participants for health and safety while at the center for 4-6 hours while they sober up
2) Screening and assessment once they sober up to gather history and determine needs
3) Development of service plans based on identified needs
4) Linking participants, who agree, to treatment and detox as needed

The Sobering Center is designed to be a short-term care facility designed as a safe location for police officers to transport individuals who are under the influence or alcohol or other substances. When operating fully, the Center is expected to serve 8000 individuals/year in full capacity. The Sobering Center will monitor the residents for safety because of risks of alcohol poisoning, choking on vomit, suffocating, or because they may have undetected medical conditions or serious head injuries.

Target Zip Codes:
The project will be implemented city wide.

Goals and Relationship to Regional Goals:

Project Goals:
The goal of the project is to offer a community based facility where individuals that have been in contact with law enforcement due to public intoxication or other substance use can receive services and referrals to address their needs without being transported to the ER.
This project meets the following regional goals:
• Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

**Challenges:**

One of the challenges for this project will be finding adequate resources for detoxification and effective, low to no cost treatment options for individuals who accept referral and treatment services. These challenges will be handled by developing a seamless referral and follow up process, regular inservice trainings and quality improvement checks, and an ongoing feedback process.

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

The performing provider expects decrease in costs to public systems (ER, criminal justice system) related to alcohol and or other substance abuse and reduction in ER visits related to alcohol and other substances. Additionally, there should be an increase in referrals to treatment programs.

**Starting Point/Baseline:**

This is a new initiative. A baseline will be established in the first year of full operation (DY3).

**Rationale:**

Other cities adopting such sobering centers have seen reductions in arrests and jail time for these offenders, as well as fewer emergency room and hospital check-ins for this often indigent population, on top of the cost savings found in jail bed diversions. In San Antonio, in the first year alone, the sobering center led to $6 million in cost savings. After three years, total cost savings from reduced jail time, reduced hospitalizations, and other sources stretches over $25 million.

**Project Components:**

There are no required project components for this project. Nevertheless, since this is a new program, processes will be refined and improved through a Plan-Do-Check-Act process. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes. It is expected that revisions to the protocol, training requirements, partnership processes and expectations will need to be clarified on a regular basis starting with the pilot implementation in DY3. These processes will be improved through the PDSA process. Initial program enrollment of a small number of target population will help iron out the program weaknesses and allow for a continuous improvement process.

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

The Sobriety Center Project also addresses the issues addressed in the following community needs assessments:

- CN.6 Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly.
- CN.23 Lack of patient navigation, patient and family education and information programs.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This is a new initiative for the City of Houston. There is currently no facility similar to a Sobering center in Houston.

**Related Category 3 Outcome Measures:**

**OD-9 Right Care, Right Setting:**

**IT – 9.4 Other Outcome Improvement Target (Non emergent ER visits and hospitalizations in Sobering Center Participants)**

Rate: Preventable admissions to ER and hospitals due to alcohol/other substance use intoxication in Sobering Center Participants in previous 6 month period

**Reasons/rational for the selecting the outcome measures:**

This facility will result in cost savings to the Health Care system. There were 187,537 ER visits projected for 2012 (projected from data from Jan to June of 2012) in Harris County Hospital District of which approximately 3% were alcohol related. This means 5626 were alcohol related ER visits per year. Other cities adopting such sobering centers have not only seen reductions in arrests and jail time for these offenders, but also fewer emergency room and hospital check-ins for this often indigent population. This approach is more effective because it addresses the underlying issue of alcohol abuse inherent in most public intoxication offenses.

**Relationship to Other Projects:**

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

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

**Project Valuation:**

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

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire...
community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category. HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The Houston Sobering Center received a composite Prioritization score of 5.35 and a Public Health Impact score of 6.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 [P – X1]</strong></td>
<td><strong>Milestone 4 [P-X3]</strong></td>
<td><strong>Milestone 6 [I-1]</strong></td>
<td><strong>Milestone 7 [I-1]</strong></td>
</tr>
<tr>
<td>Project Planning - Plan scope, range, current capacity and needed resources for Sobering Center.</td>
<td>Implement project according to project plans</td>
<td>Criminal Justice Admissions/Readmissions</td>
<td>Criminal Justice Admissions/Readmissions</td>
</tr>
<tr>
<td>Metric 1 [1-X.1]: Develop a plan for implementing Sobering Center Program and provide report that includes: Planning Materials, Meeting minutes, Sign-in sheets, Draft Clinical Protocols, Staff Qualifications, and Staffing Plan</td>
<td>Metric 1: Provide documentation of implementation</td>
<td>Metric 1 [I-1.1]: Decrease over baseline in preventable admissions and readmissions into Criminal Justice System of those who were previously arrested for public intoxication and have participated in Sobering Center program in past 6 months. (Baseline TBD in DY 3). The number of contacts is expected to decrease to 475 contacts per month from a baseline of 500 contacts.</td>
<td>Metric 1 [I-1.1]: Decrease over baseline in preventable admissions and readmissions into Criminal Justice System of those who were previously arrested for public intoxication and have participated in Sobering Center program in past 6 months.</td>
</tr>
<tr>
<td>Goal: Produce a comprehensive report documenting all information identified above</td>
<td>Goal: Implement project and initiate the quality improvement process</td>
<td>This would be measured every 6 months starting DY 4 to see if there was a decrease.</td>
<td>This would be measured every 6 months starting DY 4 to see if there was a decrease.</td>
</tr>
<tr>
<td>Data Source: Report planning materials and final summary report</td>
<td>Data Source: Program Documentation</td>
<td>Goal: Decrease in admissions and readmissions to criminal justice system by 5% over baseline in program participants</td>
<td>Goal: Decrease in admissions and readmissions to criminal justice system by 7% over baseline in program participants</td>
</tr>
<tr>
<td>$580,373.32</td>
<td>$964,854.56</td>
<td>$2,054,261.86</td>
<td>$1,985,265.74</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measures:</td>
<td>0937740-08.3.10</td>
<td>IT-9.4</td>
<td>Other Outcome Improvement Target (Non emergent ER visits and hospitalizations in Sobering Center Participants)</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Estimated Process Milestone 2 Amount: $580,373.32</td>
<td>Documentation</td>
<td>Estimated Process Milestone 5 Amount: $964,854.56</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3 [P-2.1]:</strong> Design community-based specialized interventions for target populations.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-2.1]: Project plans which are based on evidence / experience and which address the Goal: Provide completed report providing information identified above Data Source: Program documentation, HER, claims, needs assessment survey/study</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Process Milestone 3 Amount: $580,373.32</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $1,741,119.95</td>
<td>Year 3 Estimated Milestone Bundle Amount: $1,929,709.11</td>
<td>Year 4 Estimated Milestone Bundle Amount: $2,054,261.86</td>
<td>Year 5 Estimated Milestone Bundle Amount: $1,985,265.74</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $7,710,356.66</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Project Option 2.6.4 - Implement other evidence based project to implement health promotion programs in an innovative manner not described above.

Unique Project ID: 0937740-08.2.7

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

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

Intervention(s): The performing provider will implement interventions to provide an expansion of an evidence-based home visitation program for 100 first time mothers in an underserved area. This consists of 64 home visits over two and one half years for each client enrolled in the program with visits conducted weekly, bi-monthly and monthly.

Need for the Project: This expansion project provides a comprehensive evidence based care to underserved enrolled clients. Underserved clients would not normally have access to comprehensive services provided by such a program to improve birth outcomes for the child and health and social outcomes for the mother. Last year, the NFP served 146 clients with the home visitation program of which 66% were Medicaid clients. Two thirds of the women served by this NFP expansion are expected to be Medicaid recipients.

Target Population: The target population will be women who live in a geographically identified area of the city who have high rates of low birth weights and low prenatal care rates. Recruitment for the program will be conducted from the performing provider’s health clinics and WIC Centers.

Category 1 or 2 expected patient benefits: Increase the number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model by 5% over baseline in DY4 and by 10% over baseline in DY5. During DY3, 100 first time mothers will be served over two and a half years. In DY 4, the number of women served will increase to 105 to account for attrition and in DY 5, 110 mothers will be served, again accounting for attrition over the course of the program.

Category 3 outcomes: IT-8.2 Percentage of low birth weight babies - Reduce percentage of Low Birth- weight births by 2% in DY4 and by 4% in DY5 among women enrolled in the program.
IT-8.1 Timeliness of Prenatal Care - Increase by 5% over baseline number of women that receive recommended prenatal and postnatal care in DY4 and by 10% over baseline in DY5.

Project Option 2.6.4 - Implement other evidence based project to implement health promotion programs in an innovative manner not described above.
Unique Project ID: 0937740-08.2.7

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

Project Description:
This project will expand the Nurse Family Partnership (NFP), an evidence-based home visitation program for first-time mothers. NFP utilizes Bachelor prepared, Registered Nurses to conduct home visits to address multiple needs of their clients.

Public health nurses are the backbone of Nurse-Family Partnership's (NFP) success. Since the program’s inception, nurses have been instrumental in shaping and delivering this evidence-based, community health program. Because of their specialized knowledge and person-centered approach, the public health nurses who deliver the Nurse-Family Partnership program in their communities, establish trusted relationships with young, at-risk first time mothers. During home visits and follow-up contact, guidance is provided to address the emotional, social, and physical challenges these first-time moms face as they prepare to become parents. But most importantly, Nurse-Family Partnership Nurse Home Visitors make a measurable, long-lasting difference in the lives of their clients.

The NFP home visitation consist of 64 planned home visits over a two-and-a-half year period for each client. Home visits are conducted weekly, bi-monthly and monthly. The baby's father and other family members are encouraged to participate. Recruitment for NFP is conducted at Houston Department of Health and Human Services (HDHHS) Health Centers and WIC sites; other sources for recruitment include pregnancy testing centers, physician offices and self-referrals.

The greater Sunnyside area in Southeast Houston is the selected region for expansion of NFP services. Recent data revealed the Sunnyside area has an alarming rate of low weight births (14.7%), almost five (5) times the Healthy People 2010 goal of < 5.0 %. Approximately one out of five mothers report receiving late prenatal care. This area has a limited number of prenatal care facilities. According to Texas Department of Health and Human Services Commission, the Sunnyside area had a history of being disproportionately represented in the numbers of out of home placements related to abuse and neglect and is one of the highest in the state.

The NFP team consists of 1 Nurse Supervisor, 4 Bachelor of Science in Nursing prepared Registered Nurses and 1 administrative support person. Potential clients will be recruited from HDHHS Health and WIC sites, local high schools, area Pregnancy Centers, FQHCs, HMOs and other home visitation programs.

The visits consist of extensive prenatal, infant and childhood education. This comprehensive program expands to 2 ½ years, with visitations spanning weekly, bi-monthly and monthly. NFP currently collaborates with other programs that serve underserved families in low-income communities in Houston.

This intensive level of support has proven to improve outcomes relating to:
• Preventive health and prenatal practices for the mother – helping her find appropriate prenatal care, improve her diet, and reduce her use of tobacco, alcohol, and illegal substances. Additionally, NFP nurses help the mother prepare emotionally for the arrival of the baby.

• Health and development education and care for both mother and child – providing individualized awareness of specific child development milestones and behaviors, as well as encouraging parents to use praise and other nonviolent techniques.

• Life coaching for the mother and her family – enabling economic self-sufficiency among mothers by encouraging them to develop a vision for their own futures, stay in school, find employment, and plan future pregnancies.

Currently, Houston Department of Health and Human Services (HDHHS) provides NPF services in the North, Northeast and Northwest regions of Houston/Harris County. There is an emphasis in the Acres Home area in North Houston, secondary to the high rates of infant low birth weight rates (lbw). Since implementation of the NFP program, the infant lbw rates have decreased.

Goals and Relationship to Regional Goals:
The goals of the NFP project is to improve birth outcomes in underserved areas by providing a comprehensive package of services to each enrolled client over a 30 month period by well trained nurse conducting home visitations.

Project Goals:
To expand the current Nurse Family Partnership Program to the Sunnyside community and:

1. Improve pregnancy outcomes
2. Improve child health and development
3. Improve economic self-sufficiency

This project meets the following regional goals:
This project will contribute to developing a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation process. NFP is an evidence-based best practice promoted and supported by a national organization. The current program funded by the department of State Health Services is a statewide effort to improve perinatal outcomes through the NFP program.

Challenges:
One of the challenges that we anticipate are securing and maintaining a nursing staff with a suitable match between nurse’s professional/personal goals and program requirements. Regular meetings and feedback with program staff will be used as one of the means of identifying potential problem areas and overcoming some of these challenges. Opportunities for trainings and continuing education will also be offered to the project staff. The professional and personal goals of the staff will be taken into account and steps will be taken to close gaps whenever possible.

5-Year Expected Outcome for Provider and Patients:
We expect improved perinatal outcomes and improvement in indicators of child health and well-being.

Starting Point/Baseline:
Baseline data will need to be collected since the program will be expanding into a new community. Baseline data will be sought from the Department’s epidemiology area as well as from previous assessments done on the Sunnyside community. Baseline will be established in Year 2.

**Rationale:**
The NFP program has been implemented at multiple locations throughout the US. Extensive evaluation of the program conducted nationally utilizing data from multiple sites, indicates that NFP participation is predictive of better birth outcomes, including fewer pre-term births. According to the national Nurse Family Partnership website (www.nursefamilypartnership.org), data from the 1990 Nurse Family Partnership (NFP) Memphis trial noted that the NFP nurse-visited families gained academic and employment skills to become economically self-sufficient. According to this analysis, NFP services resulted in lower enrollment in Medicaid and Food Stamps, with a 9% reduction in Medicaid costs and an 11% reduction in Food Stamps costs in the 10 years following the birth of the child. Federal savings were estimated at 154% of costs, yielding a net 54% return on the federal investment.

A 2005 RAND Corporation analysis found a net benefit to society of $34,148 (and that was in 2003 dollars) per higher-risk family served, with the bulk of the savings accruing to government, equating to a $5.70 return for every dollar invested in Nurse-Family Partnership. The analysis also found that for the higher-risk families participating in the first trial in Elmira, New York, the community recovered the costs of the program by the time the child reached age four, with additional savings accruing throughout the lives of both mother and child.

Using the RAND Corporation’s figure of net benefit to society of $34,148 per higher-risk family served, it is anticipated that the 100 higher-risk families that will be served by this expansion of NFP into the Sunnyside area will yield a cost savings over one year of $3,414,800 (RAND Report)⁵. Using a 2007 report by NFP, a net return to government of $17,180 per NFP family served was realized. Using these figures, a more conservative cost savings of $1,718,000 would be realized.

**Project Components:** N/A

This project will include a component to conduct quality improvement for the project. Activities will include

- Identifying project impacts, “lessons learned” to adapt and scale the program to the local context, paying attention to possibilities of expansion to low-income, underserved areas with a high proportion of minority populations with poor birth outcomes.

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

---

⁵ What We Know and Don’t Know About the Costs and Benefits of Early Childhood Interventions. L. Karoly, P.W. Greenwood, S.S. Everingham, J. Hoube, M.R. Kilburn, C.P. Rydell, M. Sanders, and J. Chiesa. RAND Corporation, Santa Monica, CA
program enrollment of a small number of target population will help iron out the program weaknesses and allow for a continuous improvement process.

**Unique community need identification numbers the project addresses:**
The Nurse Family Partnership Expansion Project also addresses the issues addressed in the following community needs assessments:

- CN.14 High rates of poor birth outcomes and low birth-weight babies
- CN.20 Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
- CN.23 Lack of patient navigation, patient and family education and information programs

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
The project is an expansion of HDHHS’ existing Nurse Family Partnership program to a new community and to a number of pregnant women.

**Related Category 3 Outcome Measures:**
**OD-8 NFP Outcomes:**
**IT-8.2 Percentage of Low Birth-Weight Births (CHIPRA/NQF # 1382)46 (Stand-alone measure)**

- Numerator: The number of babies born weighing <2,500 grams at birth
- Denominator: All births
- Data source: Program Electronic Records

**IT-8.1 Timeliness of Prenatal/Postnatal Care (CHIPRA Core Measure/NQF #1517) (Non-standalone measure)**

- Numerator: Deliveries of live births for which women receive the following facets of prenatal and postpartum care:
  - Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.
- Denominator: Deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year
- Data source: Program Electronic Records

**Reasons/rationale for the selecting the outcome measures:**

The two outcomes selected for the NFP project are 1) Reduce Pre-term birth (born too soon) and 2) Provide timely and adequate prenatal care because of extensive evidence that improvements in these outcomes are robust indicators of positive birth outcomes.

Pre-term birth is defined as babies born alive before 37 weeks of pregnancy is completed. Being born too soon places the life of the baby in a precarious position. According to the World Health Organization, pre-term birth is the leading cause of newborn deaths (death during the first 4
weeks of life) and the second leading cause of death in children under the age of five. Many cost effective strategies have been identified and implemented to reduce pre-term birth and produce better birth outcomes such as home visitation programs and other interventions.

Provision of timely and adequate recommended prenatal care is extremely important to improve birth outcomes in low-income women who may typically not have access to regular primary and preventive care. Prenatal care given starting the first 3 months of pregnancy can have an impact on the health of the baby as well as the mother. Access to early prenatal care By allowing women and providers to identify and address health problems and behaviors that may cause particular harm during early fetal development, first-trimester prenatal care can lead to improved outcomes, according to the US Department of Health and Human Services. Early prenatal care is likely to matter most for women who are at elevated risk of poor birth outcomes due to smoking, poor nutritional status, HIV-positive status, or other serious health problems prior to pregnancy.

**Relationship to Other Projects and Plan for Learning Collaborative:**

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

Healthcare costs are significantly increased within a patient base with such aggressive chronic conditions that have gone untreated. The initiatives focused to chronic disease management focus to conditions such as asthma, hypertension, and diabetes and are similar in the approach of managing & proactively treating chronic conditions in order to reduce 30-day readmission rates, inappropriate emergency department utilization, and healthcare costs. The Region 3 Initiative grid allows a cross reference of initiatives associated with chronic disease management. (addendum)

**Project Valuation:**

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

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS
scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category. HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. NFP received a composite Prioritization score of 6.95 and a Public Health Impact score of 7.
<table>
<thead>
<tr>
<th>Milestone 1 [P-X1]: Conduct an assessment of health promotion programs that involve Nurse Home Visits at local and regional level.</th>
<th>Process Milestone 1 Estimated Incentive Payment: $754,219.67</th>
</tr>
</thead>
</table>
| Metric 1 [P-X1.1]: Document completion of assessment  
Goal: Assess needs of community and leverage partnerships  
Data Source: Performing Provider assessment and summary of findings | |
| Milestone 2 [P-2]: Development of innovative Nurse Family Partnership evidence-based project for targeted population based on the needs assessment and community priorities.  
Metric 1 [P-2.1]: Document innovational strategy and plans for implementation in target area.  
Goal: Put all processes in place to implement evidence based programs.  
Data Source: Program | Process Milestone 2 Estimated Incentive Payment: $626,934.65 |
| Milestone 3 [P-4]: Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned.  
Metric 1 [P-4.1]: Document learning and diffusion strategic plan  
Goal: Establish process and products for diffusion of message and lessons learned.  
Date Source: Performing Provider documentation of implementation by Performing Provider. | |
| Milestone 4 [P-5]: Execution of evaluation process for project innovation.  
Metric 1 [P-4.1]: Document evaluative process, tools and analytics.  
Goal: Perform process/improvement evaluation of project on a bi-yearly basis.  
Data Source: Performing Provider contract or other | |
| Milestone 5 [P-X2]: Develop outreach and marketing campaign.  
Metric 1: Community or population outreach and marketing, staff training, implement intervention  
Goal: Disseminate knowledge of strategies through verbal and print media to improve birth outcomes in the community.  
Data Source: Program documentation of dissemination materials.  
Process Milestone 5 Estimated Incentive Payment: $1,334,800.07 | |
| Milestone 6 [I-6]: Increase the number of patients in defined population receiving innovative intervention consistent with the Nurse Family Partnership evidence-based model.  
Metric 1 [I-6.1]: Percentage of women enrolled in Nurse Family Partnership based on milestone described above.  
Goal: Increase 5% over baseline which was established in Yr 3 of Milestone 7 [I-X2]: Increase the number of patients in defined population receiving innovative intervention consistent with the Nurse Family Partnership evidence-based model.  
Metric 1 [I-6.1]: Percentage of women enrolled in Nurse Family Partnership based on milestone described above.  
Goal: Increase 10% over baseline the number of patients receiving evidence based interventions In DY5, 110 women will be enrolled in NFP for DY5.  
Data Source: Documentation of target population reached, as designated in the project plan.  
Process Milestone 7 Estimated Incentive Payment: $2,579,936.77 | |
| Milestone 8 [I-6]: Increase the number of patients in defined population receiving innovative intervention consistent with the Nurse Family Partnership evidence-based model.  
Metric 1 [I-6.1]: Percentage of women enrolled in Nurse Family Partnership based on milestone described above.  
Goal: Increase 5% over baseline which was established in Yr 3 of | |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation. Documentation of evidence of innovational plan</td>
<td>Process Milestone 2 Estimated Incentive Payment: $754,219.67</td>
<td>documentation of implementation TBD by Performing Provider</td>
<td>Process Milestone 4 Estimated Incentive Payment: $626,934.65</td>
<td>Milestone 5 [P-3]: Test an evidence-based innovational project for targeted population</td>
</tr>
<tr>
<td>Metric 1 [P-3.1]: Document testing outcomes. Goal: Pilot test evidence based program in Yr 3 to make corrections and ensure smooth implementation of project. Data Source: Documentation of Nurse Family Partnership testing in target area. Process Milestone 5 Estimated Incentive Payment: $626,934.65</td>
<td></td>
<td>100 first time mothers. In DY4, 105 women will be enrolled in NFP, to account for expected attrition. Women that complete the program will have completed two and one half years with NFP. Data Source: Documentation of target population reached, as designated in the project plan.</td>
<td>Process Milestone 8 Estimated Incentive Payment: $1,334,800.07</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| Partnership based on milestone described above.  
  Baseline: Establish number of patients receiving evidence based intervention.  
  Data Source: Documentation of target population reached, as designated in the project plan.  
  Process Milestone 6 Estimated Incentive Payment: $626,934.65 | Timeliness of Prenatal/Postnatal Care (CHIPRA/NQF # 1382)46  
Pre-term Delivery Rate (CHIPRA/NQF # 1382)46 |  
 | Year 2 Estimated Milestone Bundle Amount: $2,262,659 | Year 3 Estimated Milestone Bundle Amount: $2,507,738.59 | Year 4 Estimated Milestone Bundle Amount: $2,669,600.15 | Year 5 Estimated Milestone Bundle Amount: $2,579,936.77 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5): $10,019,934.51*
City of Houston Department of Health and Human Services
Pass 2
Project Option 2.19.2 - Develop Care Management Function that integrates primary and behavioral health needs of individuals

Unique Project ID: 0937740-08.2.8

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

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas with a population of 2.1 million in 2010. HDHHS has 1,100 employees and a budget of $100,245,403. HDHHS serves the City of Houston through 44 distinct programs. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring and restaurant inspections; birth and death certificates; leadership in emergencies such as hurricanes; operates a comprehensive regional reference laboratory, provides communicable disease prevention and control services and disease surveillance and a variety of health and human services such as the Women, Infants and Children (WIC) nutrition program, senior nutrition services, family planning, oral health services and immunizations via a network of 4 health centers, 14 WIC sites and the Harris County Area Agency on Aging.

Intervention(s): This new Homeless project will serve 200 individuals who are chronically homeless and offer comprehensive service integration intervention. This project will implement its comprehensive five step intervention for the homeless involving 1) permanent housing supportive model 2) program service linkages 3) physical and behavioral health needs 4) financial support 5) other services.

Need for the Project: There is a great need for an integrated system of care for the homeless (defined as four or more bouts of homelessness in the past 3 years or more than a year of current consecutive homelessness) that will effectively house and provide supportive services. This project provides a comprehensive evidence based care to chronically homeless clients who have an ongoing need for housing, physical and behavioral health services. There are at least 2000 chronically homeless individuals in Houston according to the last count performed by the Homeless Coalition. People experiencing chronic homelessness have the following characteristics: 1) typically male (79-86%) and middle age (60% are 35-54), 2) 63% unsheltered, 3) almost 100% with presence of disabilities & frequently multiple disabilities at once and 4) frequently use emergency rooms, hospitals, mental health services, veterans’ services, substance abuse detoxification and treatment, and criminal justice resources. (Chronic Homelessness Policy Solutions, Chronic Homelessness Brief March 2010, National Alliance to End Homelessness).

Target Population: The project targets individuals with histories of mental illness, addiction, complicated medical problems and meet HUD’s definition of chronic homelessness and frequent users of hospitals and crises response systems.

Category 1 or 2 expected patient benefits: Increase patient/target population utilization rates of each aspect of program (Housing, program services, physical and behavioral needs, financial services and other services) by 2% over baseline in DY4 and by 5% over baseline in DY5. During DY3 a baseline of 175 individuals will be placed in permanent housing; in DY4, the
number of people in permanent housing will increase to 184, and in DY5 the number in permanent housing will increase to 193.

Category 3 outcomes: IT-9.4 Other Outcome Improvement Target - Reduce non emergent ED usage in program participants by 5% over baseline in DY4 and by 10% in DY 5.

Project Option: 2.19.2 (Other) Develop Care Management Function that integrates primary and behavioral health needs of individuals

**Unique Project ID:** 0937740-08.2.8  
**Performing Provider Name/TPI:** City of Houston Department of Health and Human Services/0937740-08

**Project Description:**
HDHHS proposes a comprehensive project to integrate evidence based and best practice models such Housing First to reduce chronic homelessness and associated health and other public system costs.

The project will strive to create an integrated system of care that will effectively house and provide supportive services to homeless individuals. Evidence based programs and practices (described in program components below) will be implemented and linked with permanent supportive housing in order to permanently house homeless individuals and subsequently engage them in intensive supportive services. Investments in this model of service will ultimately result in reduced health care and other public system costs to the community and increased housing stability. A collaborative partnership will be developed between the Mental Health Mental Retardation Authority in Houston, the City of Houston Housing & Health Departments, and the Houston and Harris County Housing authorities to develop, fund and implement a demonstration project that provides permanent housing and supports to 200 individuals who are chronically homeless. Housing units will be linked to intensive supportive services that are tailored to individual needs of the participants served by the project.

**Need for project**
Housing and Urban Development’s (HUD) definition of chronic homeless is four or more episodes of homelessness within the past three years or one or more current consecutive years of homelessness. In addition, the individual must have a disabling condition which makes daily activities difficult (e.g. medical, psychological, substance abuse). As reported by the Houston Homeless Coalition, over one in three (34.4%) or 1315 individuals of the 3824 unsheltered homeless people who were counted in the Point in Time (PIT) enumeration conducted in Houston in 2012 met HUD’s definition of chronic homeless.

Among those in emergency shelters, transitional housing, or safe haven on the night of the PIT count, one in four (25.7%) or 745 individuals of the 2902 sheltered homeless was classified as a
chronically homeless individual. Additional data obtained on those staying in shelters that night show that 12.9% had severe mental illness and 21.4% were chronic substance abusers. The PIT count indicates there at least 2000 homeless individuals in Houston/Harris County who meets HUDs definition of chronic homeless.

Research has shown that many chronically homeless people have disabilities such as serious mental illness, chronic substance use disorders, or chronic medical issues and are homeless repeatedly or for long period of time. People experiencing chronic homelessness have the following characteristics: 1) typically male (79-86%) and middle age (60% are 35-54), 2) 63% unsheltered, 3) almost 100% with presence of disabilities & frequently multiple disabilities at once and 4) frequently use emergency rooms, hospitals, mental health services, veterans’ services, substance abuse detoxification and treatment, and criminal justice resources. (Chronic Homelessness Policy Solutions, Chronic Homelessness Brief March 2010, National Alliance to End Homelessness). Early engagement in appropriate services to address the multiple conditions for many of these indigent individuals, as well as their needs for housing and social support, requires both behavioral health case managers and chronic disease care managers working closely to make service settings accessible and to track progress in this target group.

Some of the models that will be adapted for this demonstration project include the Corporation for Supportive Housing Frequent Users Systems Engagement (FUSE) model, Housing First, SOAR and ACT and Integrated Health Care for this project.

The FUSE process (http://www.csh.org/csh-solutions/community-work/systems-change/fuse/) will be utilized to guide the effort toward system integration. FUSE helps communities break the cycle of incarceration and homelessness among individuals with complex behavioral health challenges. The three components of the FUSE model include 1) data-driven problem solving, 2) policy and systems reform and 3) targeted housing and services. Implementation of the model will result in identification and engagement of frequent users of multiple systems (jails, homeless shelters and crisis health services, tracking and measuring of outcomes/impacts and cost-effectiveness, policy & system reforms through the work of an interagency, multi-sector work group and implementation of a Housing model that will lead to increased housing stability and reduced system costs.

Target Population
The project will target individuals with histories of mental illness, addiction, complicated medical problems and meet HUD’s definition of chronic homelessness and are frequent users of hospitals and crises response systems.

This integrated program for the homeless individuals will comprise of 1) housing, 2) program services 3) physical and behavioral medical needs 4) financial support and 5) other needs.
1) Housing
The project will use a permanent supportive housing model using the Housing First approach (http://www.seattle.gov/housing/homeless/HousingFirst.htm) as the primary solution. This intervention moves people off the street or out of temporary shelter into stable, affordable housing and combines housing with supportive treatment services in the areas of mental and physical health, substance abuse, education, and employment. Evaluations of permanent supportive housing have demonstrated significant improvements in housing stability, reduction in days of homelessness, and reductions in the utilization and costs of public services such as emergency shelter, hospital emergency room and inpatient care, sobering centers and jails. The Housing First model has been demonstrated to be effective for people with co-occurring psychiatric and substance use disorders who are homeless. The model provides a stable living environment in which various needed psychiatric services and other medical services can be delivered.

2) Program Services
Linking services with the permanent housing model is essential to achieve housing stability and to realize savings in the public systems of care. Behavioral health services will include Assertive Community Treatment services, crisis intervention and other intensive case management services. ACT is a self-contained program that serves as the fixed point of responsibility for providing treatment, rehabilitation and support services to identified consumers with severe and persistent mental illnesses and substance abuse. Using an integrated services approach, an ACT team merges clinical and rehabilitation staff expertise, e.g., psychiatric, substance abuse, employment, and housing within one mobile service delivery system. ACT team members include psychiatrists, licensed mental health professionals, registered nurses, supported employment specialists and supported housing specialists.

3) Physical and Behavioral Health Needs
Program design is inclusive of service coordination, rehabilitative services, psychiatric services, nursing services, medication management, housing support, substance abuse treatment, and vocational services. The ACT team also works with families to provide education and support. Services are need-based vs. time-limited and provided in the consumer's natural environment (i.e. permanent supported housing) the majority of the time. Services provided by an ACT team are focused on reduction of hospitalization and include outreach, engagement and stabilization. The ACT will be responsible for crisis services, hospital admissions and discharge planning.

Programs of Assertive Community Treatment have been around since the early 1970s. The original model developed by Arnold Marx, M.D., Leonard Stein, M.D., and Mary Ann Test, Ph.D., in Madison, Wisconsin, was intended to demonstrate the effectiveness of providing
comprehensive services delivered by a multi-disciplinary team to persons who had not responded to traditional mental health service approaches. Assertive Community Treatment (ACT) teams in Texas represent a system wide replication of the National Alliance for the Mentally Ill endorsed Program for Assertive Community Treatment (PACT) model. The team will implement the Dartmouth or similar model for providing health care through the use of a multi-disciplinary team approach.

4) Financial Support
SOAR is a federal program that helps states and communities increase access to Social Security disability benefits for people who are homeless or at risk of homelessness and who have mental illnesses or other co-occurring disorders. The initiative does this by creating collaborative partnerships between state and federal agencies that allow case managers and clients to more easily navigate the SSI/SDDI application process. Team members who provide case management and navigation support on the care team will be trained in SOAR to increase the number of successful applications for public benefits. Without the assistance of the SOAR program only 10-15% of homeless populations have their disability applications approved. Overall those using the SOAR process have an overall SSI/SSDI application approval rate of 71%.

5) Other services
Other services that will be provided for participants include meetings with extended family, reinforcement of coping skills, assistance in determining appropriate family and community supports, linkage into appropriate ongoing services and alumni groups facilitated by peer navigators. The project will use Certified Peer Specialists to assist homeless individuals in the recovery process. Peer Specialists are individuals who are in recovery from a mental illness and who use their lived experience to assist other individuals in their own recovery. Peer specialists provide a variety of peer support services. Their primary asset is the ability to share their story and inspire hope for recovery. (Via project specific website called “Hope”).

Additionally, the project will work to capitalize on new opportunities afforded in the Affordable Care ACT to maximize access and use of Medicaid benefits to improve access to primary care.

Goals and Relationship to Regional Goals:
The goal of the project is to offer a community based service where homeless individuals that have multiple physical and behavioral comorbidities can receive housing, medical and behavioral care, services and referrals to address their needs without being utilizing the ER.

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

Challenges:
Some of the challenges anticipated by the program are location of appropriate housing, with either renovation or new construction, access to housing vouchers or other housing funds, attracting qualified providers in adequate numbers, coordinating services across agencies and engaging chronically homeless individuals to participate in the project. These challenges will be met by collaborating with partner agencies, support of local governmental and non-governmental entities and continual quality improvement built into the program. Extensive training and education of the program staff will be implemented to make the program a success. Resistance to buy in from homeless target population will be overcome by using appropriate strategies such as peer trainers and peer support groups.

5 Year Expected Outcome for Provider and Patient:
It is expected that individuals will decrease admissions to inpatient hospitalizations, Individuals will spend majority of their time stably housed, more than half will accrue supportive services cost significantly lower than were accrued prior to program participation, and most will decrease number of days spent in jail. (SAMHSA, National Registry of Evidence Based Programs and Practices)

Starting Point/ Baseline:
Baseline data will be collected during year 2 and 3 of the project

Rationale:
Research has documented cost savings associated with housing and supportive services. These services when coupled not only achieve housing stability but also improve health outcomes and decreases the use of publicly-funded institutions

The Frequent Users of Health Services Initiative was a five-year, $10 million project jointly funded by The California Endowment and the California HealthCare Foundation. The goal of the initiative was to promote the development and implementation of innovative, integrated approaches to addressing the comprehensive health and social service needs of frequent users of emergency departments Researchers found that homeless clients connected to permanent housing had greater reductions in emergency department use and charges compared to those who remained homeless: 34% fewer emergency department visits, 27% fewer inpatient admissions, and 27% fewer inpatient days.

The Chicago Housing for Health Partnership (CHHP) is a “hospital-to-housing” effort that identifies chronically ill homeless individuals at hospitals, moves them to permanent supportive housing, and provides them with intensive case management services so that they can maintain their health and secure long-term housing stability. The Intervention Group participants had high rates of long-term substance abuse (86 percent), mental illness (46 percent), and medical
issues such as HIV/AIDS (34 percent), and hypertension (33 percent), as well as a number of other chronic medical illnesses such as diabetes and cancer. The intervention group had a relative reduction of 29% in hospitalizations, 29% in hospital days, and 24% in emergency department visits.

The Denver Housing First Collaborative (DHFC) The DHFC is designed to provide comprehensive housing and supportive services to chronically homeless individuals with disabilities. The program uses a housing first strategy combined with assertive community treatment (ACT) services, providing integrated health, mental health, substance treatment and support services. A cost-benefit analysis of the program documented an overall reduction in emergency service costs for the sample group. The total emergency related costs for the sample group declined by 72.95 percent, or nearly $600,000 in the 24 months of participation in the DHFC program compared with the 24 months prior to entry in the program. The total emergency cost savings averaged $31,545 per participant. In addition to saving taxpayers money, the local and national evaluations of the DHFC program document overall improvement in the health status and residential stability of program participants. Fifty percent of participants had documented improvements in their health status, 43 percent had improved mental health status, 15 percent had decreased their substance use, and 64 percent had improved their overall quality of life. Furthermore, the overall quality of life for the community improved as the negative impacts of individuals living and sleeping on the streets were reduced.

**Project Components:** This project does not have any specified project components. However, the project will achieve its goals by a comprehensive package consisting of the following, depending on the specific needs of the target population:

- a) Linking Participants with Housing
- b) Program Services
- c) Behavioral and Physical Health Needs
- d) Financial Services
- e) Other services

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

The Integrated Mental Health with Housing First initiative also addresses the issues addressed in the following community needs assessments:

CN.6 Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly.2,3

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

Although various models exist to meet the needs of an indigent population, this program adopts and adapts critical elements of many of these evidence based programs (described in the narrative) to improve health and social outcomes in the homeless populations enrolled in this program. Additionally, the program is also innovative because it utilizes peer trainers who can
provide a unique perspective and help new program enrollees achieve success in program outcomes.

**Related Category 3 Outcome Measures:**

**Reasons/rationale for selecting the outcome measures:**

Indigent homeless individuals typically suffer from multiple comorbidities. Along with physical health problems many, if not most also suffer from mental health conditions. These comorbidities and the resulting poor health is compounded by their unstable living conditions. We chose to measure non-emergent inappropriate ED use as our outcome measure. By providing a comprehensive set of services through our program for those enrolled including access to physical (primary care) and behavioral providers and addressing their housing needs, we expect reduced ED use in these individuals.

According to a recent study from 2010, homeless people who seek care in urban EDs come by ambulance, lack medical insurance, and have psychiatric and substance abuse diagnoses more often than non-homeless people. The high incidence of repeat ED visits and frequent hospital use identifies a pressing need for policy remedies. Compared with others, ED visits by homeless people were four times more likely to occur within three days of a prior ED evaluation, and more than twice as likely to occur within a week of hospitalization. This indicates the need to address the frequent inappropriate ED use by the homeless population at greater numbers than others. [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2848264/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2848264/)

**Relationship to Other Projects:**

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**

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

**Project valuation:**

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

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

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The Integrated Services for the Homeless Program received a composite Prioritization score of and a Public Health Impact score of 5.
<table>
<thead>
<tr>
<th>Process Milestones and Metrics</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 [P-X1]</strong></td>
<td>Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric: Document plan as described above</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Plan all elements of project in order to Data Source: Program Materials</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$807,160.14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 2 [P-2]</strong></td>
<td>Identify community agencies that have the relevant data to identify the service utilization patterns of persons with co-occurring disorders.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P-2.1. Metric: Listing of relevant agencies and the data elements each has available.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Identify partners for data sharing Data Source: Records of lead organization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 4 [P-X2]</strong></td>
<td>Develop and test data systems Metric: identify, select and test data system Goal: Implement efficient data system for project Data Source: Project documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric: $1,358,827.18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5 [P-X3]</strong></td>
<td>Implement community-based specialized interventions for homeless populations based on evidence based best practice models to include:  • Transition assistance – assistance to establish a basic housing and household  • Transportation to appointments and community-based activities;  • Assertive Community Therapy  • Prescription medications;  • Certified Peer Specialists support Metric: Evidence of implementation of project plans which are based on evidence / experience and which address the project goals Metric: Intervention implemented with above elements Goal: Implementation of program according to project plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric: $1,470,441</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 6 [I-X1]</strong></td>
<td>Describe and document Target population (homeless) reached Metric: Increase the number of target population reached Goal: Increase number of homeless individuals enrolled in data system by 5% from baseline of 175 to 184 in DY4. Data Source: Program data and EHR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$1,415,687.23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 7 [I-X2]</strong></td>
<td>Changes in patient/target population utilization rates of each aspect of program (Housing, program services, physical and behavioral needs, financial services and other services) Metric: Document changes in rates of utilization of services Goal: Increase by 5% the average times each service is used. Data Source: Program data documentation, EHR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 8 [I-X1]</strong></td>
<td>Describe and document Target population (homeless) reached Metric: Increase the number of target population reached by 10% Goal: Increase number of homeless individuals enrolled in data system increased by 10% over baseline to 193 individuals. Data Source: Program data and HER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$1,415,687.23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 9 [I-X2]</strong></td>
<td>Changes in patient/target population utilization rates of each aspect of program (Housing, program services, physical and behavioral needs, financial services and other services) Metric: Document changes in rates of utilization of services Goal: Increase by 5% the average times each service is used. Data Source: Program data documentation, EHR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$1,415,687.23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Milestone 3 [P-6]** Milestone: Care coordination protocols are developed.

P-6.1. Metric: Written protocols are easily available to staff.
Data Source: Written protocols

Goal: Systematic protocols for care coordination
Data Source: Project documentation

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Estimate Incentive Bundle Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>$2,421,480</td>
</tr>
<tr>
<td>3</td>
<td>$2,717,654</td>
</tr>
<tr>
<td>4</td>
<td>$2,940,883</td>
</tr>
<tr>
<td>5</td>
<td>$2,831,374</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $10,911,392*
Project Option 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.)

Unique Project ID: 0937740-08.2.9

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

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs.

Intervention(s): The interventions for this new colorectal cancer (CRC) integrated awareness and screening (COCAS) project are to provide CRC FIT screening for 320 new individuals in DY4 and 460 new individuals in DY5, for the two target geographic areas combined; in twelve spatially identified, primarily African American, high risk zip codes. It will involve: 1) Awareness raising small media campaign utilizing culturally appropriate messages, 2) CRC Education about Screening Guidelines and Recommendations, 3) Access to Community wide Non-invasive FIT testing, 4) Test taking training, 5) Testing by nationally accredited laboratory, 6) Sharing of test results, communication and Follow up protocol as appropriate, and 7) Patient Care Navigation for getting individuals situated in a medical home in the targeted zip codes. The total number of individuals reached by COCAS through the integrated project in two target areas will be 800 in Baseline DY3, 840 in DY 4 and 856 in DY5.

Need for the Project: Screening for CRC can test for disease in early stages before symptoms occur. This can prevent morbidity and mortality due to CRC. Significant disparities exist in CRC outcomes with low income, minorities having the poorest outcomes. Screening rates for CRC by a population level, non-invasive method (FOBT) is low in Harris County. This project aims to increase screening rates through a comprehensive program in high risk zip codes.

Target Population: The target population for this project are 50-75 year old men and women (in keeping with the screening guidelines) in twelve high risk zip codes (with previously identified age adjusted spatial clusters of late stage CRC diagnosis) indicating lack of timely screening.

Category 1 or 2 expected patient benefits: Increase number of patients in defined population receiving innovative intervention consistent with evidence-based model by 60% over baseline in DY4 and by 80% over baseline in DY5. The number of new individuals reached by the integrated intervention are 800 in DY3 and 840 in DY4 and 856 in DY5. Of these, 200 will receive FIT screening in DY3 and 320 in DY4 and 460 in DY5.
Category 3 outcomes: IT-6.1 Percent improvement over baseline of patient satisfaction scores (Patients are getting timely care, appointments, and information). –Standalone measure. The integrated COCAS project is expected to increase patient satisfaction scores due to its focus on bridging patient, system and provider related barriers.

Project Option 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.)

Unique Project ID: 0937740-08.2.9

Performing Provider/TPI: City of Houston Department of Health and Human Services/ 0937740-08.2.8

Project Description:
The Colorectal Cancer Awareness and Screening (COCAS) project aims to increase colorectal cancer screening rates by 5% over baseline in previously identified high risk zip codes among 50-75 year old males and females using FOBT and alleviate health disparities in CRC outcomes. Regular screening FOBT can reduce colorectal cancer deaths by 15-33% \(^1-3\).

Community based cancer prevention interventions are categorized as one or a combination of the following: access to screening, mass media, small media, one on one and small group education, or a combination of these. The COCAS project will achieve its objectives by providing the following: 1) Awareness small media campaign utilizing culturally appropriate messages, 2) CRC Education about Screening Guidelines and Recommendations, 3) Access to Community wide Non-invasive FIT testing, 4) Test taking training, 5) Testing by nationally accredited laboratory, 6) Sharing of test results, communication and Follow up protocol, and 7) Patient Care Navigation for getting individuals to situated in a medical home in the targeted zip codes.

Colorectal cancer (CRC) is the third most common cancer and the third leading cause of cancer death in both men and women in the United States\(^4\). Despite a steady decline in overall cancer incidence and mortality rates\(^5,6\), an estimated 141,210 new cases of colorectal cancer and 49,380 deaths from this disease are expected to occur in 2011. Certain cancers in minority groups have failed to decline\(^4\) and relative geographic disparity in certain regions has remained stable\(^6\).

For 2012, The American Cancer Society's estimates the number of colorectal cancer cases in the United States are for 2012:

- 103,170 new cases of colon cancer
- 40,290 new cases of rectal cancer

The lifetime risk for developing colorectal cancer is about 1 in 20 (5.1%). This risk is slightly higher in men than in women\(^4\).

Disparities in Colorectal Cancer Morbidity and Mortality: Colorectal cancer incidence and mortality show extreme health disparities, with a disproportionate burden occurring in certain
minority populations, including African Americans and Alaska Natives. The COCAS Project will aim to increase CRC screening at the community level among all individuals in the target zip codes but will particularly focus on African Americans since the greatest disparity in morbidity and mortality are among this population.

Why is screening and early detection important? Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. Current levels of screening in this country lag behind those of other developed countries. It has been estimated that attainment of goals for population colorectal cancer screening could save 18,800 lives per year. The death rate (the number of deaths per 100,000 people per year) from colorectal cancer has been dropping for more than 20 years. There are a number of likely reasons for this. One is that polyps are being found by screening and removed before they can develop into cancers. Screening also allows more colorectal cancers to be found earlier, when the disease is easier to cure. In addition, treatment for colorectal cancer has improved over the last several years. As a result, there are now more than 1 million survivors of colorectal cancer in the United States.

Despite this, Texas falls in the list of States with the lowest screening rates in the country. According to the Behavioral Risk Factor Surveillance system (BRFSS), only 54.1-59.2% of adults aged 50-75 self-reported being up to date with colorectal cancer screening. http://www.cdc.gov/cancer/colorectal/statistics/screening_rates.htm.

In over two decades of research it has been established that screening rates can be improved through a variety of community based and clinic based techniques. (Pasick, Hiatt, & Paskett, 2004). The most effective interventions have combined multiple strategies to achieve the most optimum outcomes.

The COCAS Project will focus on increasing screening and removing barriers to screening among 50-75 year olds through community level evidence based strategies that are culturally appropriate in high risk zip codes. The project will provide materials for an awareness campaign in targeted zip codes, provide small group education, provide access to screening and lab testing facilities and enlist community health workers as patient navigators to connect all enrolled community members access to primary care, preventive care and a medical home. Assistance with enrollment and the effect of the Affordable Care Act on preventive care will be clarified. Those that need follow up care will be connected to a sliding scale (if needed) County facility through their medical home. All enrollees will be referred to a medical home and will be under the care of a medical provider, if they are not already.

United States Preventive Service Task Force (USPSTF) Assessment: Major organizations such as U.S. Preventive Services Task Force, USPSTF, (a group of experts convened by the U.S. Public Health Service), the American Cancer Society, and professional societies, have developed guidelines for colorectal cancer screening. The USPSTF recommends screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults,
beginning at age 50 years and continuing until age 75 years and grades these screening strategies as an “A”. The USPSTF concludes that, for fecal occult blood testing, flexible sigmoidoscopy, and colonoscopy to screen for colorectal cancer, there is high certainty that the net benefit is substantial for adults age 50 to 75 years. The test used will be High-Sensitivity Fecal Occult Blood Test (FOBT) or Stool Test; or Fecal Immunochemical Test (FIT) Note: There are two types of FOBT: one uses the chemical guaiac to detect blood. The other—a fecal immunochemical test (FIT) uses antibodies to detect blood in the stool.

The COCAS Project will focus on removing barriers to FOBT testing at the community level by providing ready access to education, screening and testing and in encouraging adherence to screening guidelines. National results showed there was capacity to screen everyone in need of colorectal cancer screening within one year using fecal occult blood tests (FOBTs) followed by colonoscopy for those who tested positive.1,2 Studies have shown that FOBT, when performed every 1 to 2 years in people ages 50 to 80, can help reduce the number of deaths due to colorectal cancer by 15 to 33 percent (1-3). CDC conducted the study at the national level and in selected states (Colorado, Georgia, Iowa, Maine, Maryland, Massachusetts, Minnesota, Michigan, New Mexico, New York, North Carolina, South Carolina, Ohio, Texas, and Washington). National results showed that it would take five to 10 years to develop the resources to screen everyone as recommended using only colonoscopy or flexible sigmoidoscopy. However, several states had enough resources to screen with these two tests within three years.1,2

**Target Zip Codes:** To locate high risk areas, age-adjusted purely spatial cluster analysis identified twelve statistically significant clusters of CRC incidence. The primary cluster was located in south central Houston, an area referred to as “Sunnyside,” a low-income African American community. Adjusting for area-level poverty made little discernible impact on the spatial distribution of these clusters, suggesting that poverty rate did not explain these findings. A similar analysis of late stage diagnosis identified 157 significant clusters across the study area, with the primary cluster again in the Sunnyside area. Adjusting for poverty eliminated all clusters with the exception of clusters in southeast Houston (Sunnyside) area for late-stage diagnosis, suggesting that areas with elevated late-stage CRC incidence were due to high poverty in these areas, with Sunnyside being an exception since factors in addition to poverty appeared to be contributing to the high rates. Significant spatial clustering of incidence appeared during two time intervals within the 13-year span of data. The earlier time period (1996-2001) shows a more widely dispersed arrangement of clusters in south central, southwest, and northwest Houston, with the primary cluster in the Southeast Houston (Sunnyside) area. The latter time period (2002-2007), however, indicates that clustering shifted toward north central and northeast Houston, with the strongest clustering in the northeast (Trinity/Houston Gardens) area.

The COCAS Project will focus on these two areas of the city that were identified as having the most significant clustering of late stage diagnosis. The two areas and the corresponding zip codes are Sunnyside – 77021, 77033, 77045, 77047, 77048, 77051, 77054, 77061, 77087; Trinity-Houston Gardens – 77016, 77026, and 77028.
Goals and Relationship to Regional Goals:

The goals of the project are to increase screening rates in high risk zip codes and encourage adherence to screening guidelines in order to alleviate disparities in CRC outcomes in targeted areas. This project meets the following regional goals: Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

Challenges:

The performing provider anticipates that there will be challenges in buy-in and recruitment from the target population. There are expected to be challenges in enlisting stakeholders and partners to make the COCAS project a success. Resistance and push back in behavior change regarding preventive care is also expected. The project team will prepare to address these challenges and will have strategies in place to conduct both passive and active recruitment into the COCAS project. The recruitment venues will be expanded to be community wide. Screening kits will be provided and access to testing will be facilitated for those enrolled in the COCAS Project.

5 Year Expected Outcome for Providers and Patients:

The performing provider expects that there will be an increase in screening knowledge, awareness and recommended guidelines. An increase in screening is also expected during this time in the target communities. The impact of the Affordable Care Act and its implications on cancer screening will also unfold during this time and changes are expected that will make available widespread screening in the community.

Starting Point/Baseline:

Baseline rates will be established in year 2-3 of the project. All improvements will be measured against the baseline.

Rationale:

People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur.

Previous research shows that access to screening and removal of barriers to access are the most effective means of improving screening rates. Assuring that there is appropriate follow up after screening is critical for the successful implementation of an intervention.

Project Components:

This project does not have specified components. However, the project will address: 1) Awareness campaign utilizing culturally appropriate messages, 2) CRC Education about Screening Guidelines and Recommendations, 3) Access to Community wide Non-invasive FIT
testing, 4) Test taking training, 5) Testing by nationally accredited laboratory, 6) Sharing of test results, communication and Follow up protocol, and 7) Patient Care Navigation for getting enrolled individuals to situated in a medical home in the targeted zip codes.

Unique community need identification numbers that project addresses:

CN.20 Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs

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

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

The COCAS Project represents a new initiative because 1) it is a community based population health screening initiative 2) it addresses and aims to alleviate health disparities in CRC morbidity 3) it is targeted to specific geographic areas in the city 4) it aims to use materials and intervention strategies that are culturally appropriate 5) it will be one of the first widespread community screening projects where all aspects of access to screening and removal of barriers is addressed.

Quality improvement procedures will be put in place and lessons learned will be shared. Opportunities to scale up the COCAS project in additional high risk target areas will be examined.

Related Category 3 Outcome Measures: IT-6.1 Percent improvement over baseline of patient satisfaction scores (are getting timely care, appointments, and information) – Standalone Measure.

Reasons /rationale for selecting the outcome measures:

The two outcome measures selected were 1) Improve CRC screening rates at a large scale population level 2) Improve utilization of preventive services according to established guidelines to alleviate health disparities. The COCAS Project will promote FOBT testing at a community level. The national body of experts, USPSTF, has graded CRC Screening utilizing FOBT as “A”, the highest rating for an intervention – which indicates that this Taskforce has established FOBT has having a significant net benefit in reducing morbidity and mortality due to CRC. The guidelines suggest that those that have a positive FOBT, will need to get a colonoscopy as a follow-up test to detect polyps or other conditions. Additionally, all those who were screened positive by FOBT have a high likelihood of getting follow-up screening, if needed, within one year since most States have the capacity to complete this. Colonoscopy is recommended once every ten years and has some risks associated with it, in addition to being costly. It is not feasible
to screen for CRC using colonoscopies at the widespread population level. FOBT is preferable at a widespread community level because of its easy administration, non-invasive nature, low cost and ease of follow-up.

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**

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

**Project Valuation:**

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

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

HDHHS gave the Prioritization score a weight of 50% and the Public Health Impact score a weight of 50% to determine the overall project value for the plan. CRC received a composite Prioritization score of 2.29 and a Public Health Impact score of 2.29.


### Related Category 3 Outcome Measures:

<table>
<thead>
<tr>
<th>Year</th>
<th>Year</th>
<th>Year</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Milestone 1 [P-X1] Project Planning**
- **Metric:** Engage stakeholders, identify resources and potential partnerships, develop relationships, develop implementation plan
- **Goal:** Produce a comprehensive report documenting all points above
- **Data Source:** Program Documentation
- **Milestone 1 Estimated Incentive Payment:** $184,839.67

**Milestone 2 [P-X2]: Establish baseline screening rates and adherence to screening guidelines in**

**Milestone 3 [P-X3]: Implement evidence-based innovative project for targeted population**

**Milestone 4 [P-2]: Implement evidence-based innovative project for targeted population**
- **P-2.1. Metric:** Document implementation strategy and testing outcomes.
- **Data Source:** Performing Provider program materials or other documentation of implementation TBD by Performing Provider.
- **Goal:** Implement evidence-based program to increase screening in target population.
- **Milestone 4 Estimated Incentive Payment:** $155,585.75

**Milestone 5 [P-X4]: Establish baseline screening rates and adherence to screening guidelines in**

**Milestone 6 [P-X5]: Implement evidence-based innovative project for targeted population**

**Milestone 7 [P-X6]: Establish baseline screening rates and adherence to screening guidelines in**

**Milestone 8 [I-5]: Identify number of patients in defined population receiving innovative intervention consistent with evidence-based model.**
- **I-5.1. Metric:** Increase by 60% over baseline the number of individuals of target population reached for FIT Screening.
  - **a. Numerator:** Number of individuals of target population reached by the innovative project.
  - **b. Denominator:** Number of individuals in the target population
- **Goal:** Increase by 60% over baseline to 460 in DY5 the number of new individuals enrolled in COCAS Program that received FIT Screening.

**Milestone 9 [I-5]: Identify number of patients in defined population receiving innovative intervention consistent with evidence-based model.**
- **I-5.1. Metric:** Increase by 80% over baseline the number of individuals of target population reached for FIT Screening.
  - **a. Numerator:** Number of individuals of target population reached by the innovative project.
  - **b. Denominator:** Number of individuals in the target population
- **Goal:** Increase by 80% over baseline to 460 in DY5 the number of new individuals enrolled in COCAS Program that received FIT Screening.
**Project Components:**

**Project Title:** Colorectal Cancer Awareness and Screening Project (COCAS)

**Performing Provider Name:** City of Houston Health and Human Services

**TPI:** 0937740-08

**Related Category 3 Outcome Measures:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Target Zip Codes</th>
<th>Percent Improvement Over Baseline of Patient Satisfaction Scores (Patients are getting timely care, appointments, and information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
<td>0937740-08.3.13 IT-6.1</td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 2 Estimated Incentive Payment:** $184,839.67

**Milestone 3 [P-X3]** Develop culturally appropriate targeted materials for increasing awareness of CRC screening.

**Metric:** Plans and evidence of development of targeted materials.

**Goal:** Development and adaptation of materials to be used for

**Milestone 5 [P-X3]:** Plan evaluation design for innovative evidence based project.

**Metric:** Written evaluation plan documentation.

**Goal:** Develop systematic plan to evaluate project in order inform scaling of screening intervention project.

**Milestone 5 Estimated Incentive Payment:** $155,585.75

**Milestone 8 Estimated Incentive Payment:** $336,731

**Milestone 9 [I-7]:** Increase access to disease prevention programs using innovative project option.

**Metric:** Increased by 5% over baseline number of total encounters as defined by intervention (e.g., screenings, education, outreach, etc.) from 800 to 840 in DY4.

**a. Total Number of Visits for Enrollees Reporting Period**

**Milestone 10 Estimated Incentive Payment:** $324,192.50

**Milestone 11 [I-7]:** Increase access to disease prevention programs using innovative project option.

**I-7.2. Metric:** Increased by 7% over baseline number of encounters as defined by intervention (e.g., screenings, education, outreach, etc.) to 856 in DY5.

**a. Total Number of Visits for Enrollees Reporting Period**
<table>
<thead>
<tr>
<th><strong>UNIQUE IDENTIFIER</strong></th>
<th><strong>RHP PP REFERENCE NUMBER:</strong> 2.7.1</th>
<th><strong>PROJECT COMPONENTS:</strong> 2.7.1</th>
<th><strong>PROJECT TITLE:</strong> Colorectal Cancer Awareness and Screening Project (COCAS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0937740-08.2.9</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**Related Category 3 Outcome Measures:**  
0937740-08.3.13 IT-6.1  
Percent improvement over baseline of patient satisfaction scores (Patients are getting timely care, appointments, and information)

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Awareness Building**  
Milestone 3 Estimated Incentive Payment: $184,839.67  

- a. Data Source: Performing Provider documentation of learning and diffusion strategy of implementation  
  Goal: Diffusion of knowledge and strategy communicated over certain channels.
  Milestone 6 Estimated Incentive Payment: $155,585.75  
  Milestone 7 [P-4]. Milestone: Execution of evaluation process for project innovation.  
  Data Source: Performing Provider documentation of implementation

- b. Data Source: Registry,  
  Milestone 9 Estimated Incentive Payment: $336,731  
  Milestone 11 Estimated Incentive Payment: $324,192.50

**Data Source:** Performing Provider documentation of implementation

**Regional Healthcare Partnership Plan**  
Region 3

1044
<table>
<thead>
<tr>
<th>UNIQUE IDENTIFIER</th>
<th>RHP PP REFERENCE NUMBER: 2.7.1</th>
<th>PROJECT COMPONENTS: 2.7.1</th>
<th>PROJECT TITLE: Colorectal Cancer Awareness and Screening Project (COCAS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing Provider Name: City of Houston Health and Human Services</td>
<td>TPI - 0937740-08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measures:</td>
<td>0937740-08.3.13</td>
<td>IT-6.1</td>
<td>Percent improvement over baseline of patient satisfaction scores(Patients are getting timely care, appointments, and information)</td>
</tr>
<tr>
<td><strong>Goal:</strong> Develop and implement an evaluation plan.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 7 Estimated Incentive Payment: $155,585.75</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $554,519</td>
<td>Year 3 Estimated Outcome Amount: $622,343</td>
<td>Year 4 Estimated Outcome Amount: $673,462</td>
<td>Year 5 Estimated Outcome Amount: $648,385</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundles amounts over DYs 2-5):</strong> $2,498,709</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
City of Houston Department of Health and Human Services
Pass 3
2.12.3: Implement/Expand Care Transitions Programs, “Other” project option to reduce the incidence of hospital readmissions within 30 days of discharge of Medicare Fee For Service and Dual Eligible individuals that are hospitalized resulting from chronic disease such as Heart Failure (HF).

**Unique Project ID:** 0937740-08.2.1

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

**Project Summary:** Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 4 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

Intervention(s): This expansion project, modeled after an existing Coleman Transitions Intervention, utilizes case managers, coaches and navigators to improve transitions of patients from the inpatient hospital setting to other care settings, improve quality of care, reduce avoidable readmissions for high risk heart failure beneficiaries and document measurable savings to the Medicare program.

Need for the Project: Many patients discharged from an inpatient return to the hospital within 30 days. Nearly one in five patients discharged from a hospital—approximately 2.6 million individuals—is readmitted within 30 days, at a cost of over $26 billion every year. Many of these hospital readmissions are considered to be avoidable and indicators of poor care or missed opportunities to better coordinate care.

Target Population: The primary target population is at risk patients ages 60 years or older. The majority of clients will be Medicaid or Medicare beneficiaries. This project will expand to additional geographic areas beyond the area covered by the current project. It is expected that 25% of the patients referred for the Care Transitions Program through the Methodist Hospital System will be Medicaid patients. In addition to this, a proportion of patients will be dual-eligible. Medicaid patients with CHF from the large Methodist Hospital System will be channeled to the Care Transitions program for meeting the needs of the program’s target population.

Category 1 or 2 expected patient benefits: [ I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care
transitions policies by 5% over baseline in DY4 and by 10% over baseline in DY5. 30 patients/month will be enrolled in DY3 for baseline, and 40 patients/month in DY4 and 50 patients/month will be enrolled in DY5.

Category 3 outcomes 1 [IT-3.2] Reduce Congestive Heart Failure 30 day readmission rate by 10% over baseline in DY4 and by 25% over baseline in DY5 among individuals that complete the program.

2.12.3: Implement/Expand Care Transitions Programs, “Other” project option to reduce the incidence of hospital readmissions within 30 days of discharge of Medicare Fee For Service and Dual Eligible individuals that are hospitalized resulting from the chronic disease specifically, Congestive Heart Failure (CHF).

Unique Project ID: 0937740-08.2.10

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

Project Description:
The performing provider, Houston Department of Health and Human Services (HDHHS) proposes to implement a program, modeled after Coleman Transitions Intervention to improve transitions of patients from the inpatient hospital setting to other care settings, to improve quality of care, to reduce avoidable readmissions for high risk heart failure beneficiaries, and to document measurable savings to the Medicare program.

Hospitalizations are costly, accounting for approximately 31 percent of total health care expenditures. Many patients discharged from an inpatient return to the hospital within 30 days. In Medicare, inpatient care accounts for 37 percent of spending, and readmissions contribute significantly to that cost: Nearly one in five patients discharged from a hospital—approximately 2.6 million seniors—is readmitted within 30 days, at a cost of over $26 billion every year. Some of these readmissions are planned, and others may be part of the natural course of treatment for specific conditions; but, increasingly, some hospital readmissions are considered to be avoidable and indicators of poor care or missed opportunities to better coordinate care.

Hospital readmissions may be prevented. With nearly one in five Medicare patients returning to the hospital within a month of discharge, the government considers readmissions a prime symptom of an overly expensive and uncoordinated health system. Multiple factors contribute to avoidable hospital readmissions: they may result from poor quality care or from poor transitions between different providers and care settings. Likewise, such readmissions may occur if patients are discharged from hospitals or other health care settings prematurely, are discharged to inappropriate settings, or do not receive adequate information or resources to ensure continued progression. A lack of system factors, such as coordinated care and seamless communication and information exchange between inpatient and community-based providers, may also lead to unplanned readmissions. Hospital readmissions may adversely impact payer and provider costs and patient morale. Repeated hospital admissions may also demoralize patients and leave them feeling lost and confused.
CMS has recognized that it is important for the medical community to work collaboratively with community based organizations and other local service providers to address hospital readmissions. This performing provider will expand upon a partnership with The Methodist Hospital part of the Methodist Hospital System (TMHA) to expand a Community Care Transitions Program (CCTP) using the Coleman Care Transitions evidence based model. The performing provider conducts an existing CCTP project through the same partnership. It is expected that 25% of the patients referred for the Care Transitions Program through the Methodist Hospital System will be Medicaid patients. In addition to this a proportion of patients will be dual-eligible. Medicaid patients with CHF from the large Methodist Hospital System will be channeled to the Care Transitions program.

**Recruitment strategy and program promotion**-All hospital staff will receive oral and written communication through hospital leadership such as the Chief Operating Officer and the Chief Nursing Officer regarding the hospital care transitions program. Physicians, nurses, social workers, and other professionals will be encouraged to flag any patient with CHF so that the Transitions Coach can formally invite them to participate in the program. Physicians and staff nurses will be given direction on how to share the program benefits with patients. Program notification and beneficiary communication materials will be posted and distributed throughout the hospital.

Families of admitted patients will receive information about this program as part of the admission process. Visual displays describing the program will be posted in the inpatient areas and Emergency Room so that patients and/or families are prompted to ask questions. A “Fast-Facts” explaining the program will also be sent to physicians with hospital privileges who admit patients from the community, describing the benefits of the program and encouraging their identification of Medicare patients who may be eligible. This communication method will also be used to update physicians regarding the results of the program. When qualified patients are identified as not enrolling in the program, an analysis will be done to identify methods that may be employed in the future to facilitate enrollment. Additionally, hospital staff will receive reminders about the program at regularly scheduled monthly service line staff meetings.

If a patient who is a Medicare and/or Medicaid beneficiary or an at risk 60 year old or older and is admitted to the hospital with an diagnosis of CHF and it is determined by the hospital that the patient is at high risk for readmission, the patient will be asked if they are interested in participating in the Care Transitions Program (CTP). Participants will be placed in a Tier System based on the level of need and physical impairment. Social Workers/Case Managers will be trained to be Coaches in the Care Transitions Intervention to assist patients. A Social Worker/Case Manager team lead will triage Coaches based on the Tier system. Tier 1 will address the most critical needs. This team will consist of Coaches only. Tier 2 will address intermediate needs. This team will consist of a Coach with assistance from a Navigator. Tier 3 will address minimal needs. If necessary, the Navigator will consult with a Coach. Coaches will work with Navigators when necessary based on the Tier system. Navigators will assist with information, referral and assistance and activities of daily living in the home if needed.

Cost savings to the Health Care system and CMS are projected at $864,000, $1,296,000 and $1,728,000, $2,160,000 for years 1,2,3 and 4 respectively.
It is important to note that this cost savings is only derived based on the anticipated reduction in readmissions, and does not include expected savings from other reductions or changes in patient utilization patterns; the performing provider considers this to be a conservative estimate of the real savings and efficiencies the CCTP program will achieve.

The recruitment strategy is as follows:
The case manager/discharge planner from the Methodist Hospital system will assess whether the CHF patient is a good candidate for the program. If the patient is at risk for readmission, a referral will be sent to the Coach by the case manager/discharge planner. The Coach will ask the patient if they want to participate in the program and explain the four pillars of the Coleman Transitions Intervention. If the patient agrees to participate, consent will be obtained.

The hospital case manager/discharge planner will consult with the Coach 48 hours before discharge to ensure a smooth transition from the hospital to the home setting. The Coach will visit the patient to review the four pillars in more depth, arrange a home visit for 48-72 hours post-discharge and a post-discharge follow-up doctor’s visit will be set. The Coach and hospital case manager/discharge planner will review the patient’s discharge plan to determine if any in-home or ancillary services such as home delivered meals, personal care or Benefits Counseling provided by the Harris County Area Agency on Aging (HCAA) or other organizations are needed. These items will be noted and discussed with the patient prior to discharge. When the caller returns home, the Coach will contact the patient or family member 48-72 hours after discharge to solidify the time of the home visit. During the initial home visit, the Coach will help the patient complete the PHR. The Medication Discrepancies tool will also be completed.

When it is determined that supportive services such as emergency response, in-home respite, medication management, home delivered meals, personal assistance services, transportation and/or longer term Care Management are needed to facilitate patients’ compliance with discharge orders and optimize patient recovery, the services will be coordinated and/or provided by the Harris County Area Agency on Aging and the Care Connection Aging and Disability Center. The Coach will make two follow up phone calls on days seven and 14 to reinforce the four pillars of the CTI. On Day 30, the Transitions Coach will administer the Care Transitions and Patient Activation Measures. Follow up will be conducted Days 60, 90 and 180 to ensure ongoing adherence to the four pillars, discharge plan, ensure that the patient has secured a medical home and to determine if the patient has been readmitted to the hospital within the 180 day period after discharge.

Patients with congestive heart failure and with the strongest positive association with readmission were discharged against medical advice and covered by Medicaid had more severe loss of function and certain comorbidities such as drug abuse, renal failure, or psychoses. Additionally, nearly one in five patients discharged from a hospital—approximately 2.6 million seniors—is readmitted within 30 days, at a cost of over $26 billion every year. CMS cites $9600 as average cost of hospital admission and readmission.

- The performing provider in partnership with TMHS-TMC will enroll 30 patients per month in DY3 with a projected 25% reduction in readmission;
- 40 patients per month will be enrolled in DY4 with a projected 25% reduction in readmission;
• 50 patients per month will be enrolled in DY5 with a projected 25% reduction in readmission;

Goals and Relationship to Regional Goals:
The goals of the project are to expand existing Community Care Transitions project/strategies through partnership with Methodist Hospital System and

- reduce 30 day readmissions rates of Medicaid, Medicare FFS and Dual Eligible CHF patients
- maintain or improve quality of care
- document measurable savings to the Medicaid program

The CCTP project meets the following regional goal by reducing readmissions: Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system,

Project Goals:
The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measurable savings to the Medicare program

Expected Outcomes:
Implement CCTP strategies to address factors that contribute to avoidable hospital readmissions and will reduce incidence of hospital readmissions of patients with diagnosis of CHF.

Baseline Data:
Baseline data will be collected from CMS Hospital Compare readmission rates. Program baseline will be established in DY 3.

Community Needs Assessment
This project meets the following community needs assessments.
CN.9: High rates of preventable hospital readmissions
CN.7: Insufficient access to care coordination practice management and integrated care treatment programs.

Challenges:
The performing provider anticipates that there will be challenges in buy-in and recruitment from the target population. Other anticipated challenges are patient education for minimally educated and linguistically isolated patients, incentivizing patients to commit to the program in total (as some patients will agree to participate while hospitalized, but due to day to day stressors of this population will not follow through with program post discharge), home based care for patients with limited family support.

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

**Related Category 3 Outcome Measures:**

**IT-3.2 Congestive Heart Failure 30 day readmission rate**

**Reasons/rationale for selecting the outcome measures:**

Heart failure is associated with high rehospitalization rates, often due to preventable complications resulting from patients' inability to adequately self-manage the condition and poorly implemented transitions to the next care setting. Programs that provide adequate guidance at discharge, appropriate medication management, and appropriate follow-up with patients during times of transition can reduce readmission rates and improve quality of care. Therefore reduced rehospitalization was chosen as the outcome measure.

([http://www.innovations.ahrq.gov/content.aspx?id=2206](http://www.innovations.ahrq.gov/content.aspx?id=2206)).

**Relationship to Other Performing Providers’ Projects and Plan for Learning Collaborative:**

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

**Project valuation:**

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

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program.
scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category. HDHHS gave the Prioritization score a weight of 50% and the Public Health Impact score a weight of 50% to determine the overall project value for the plan. The Integrated Services for the Homeless Program received a composite Prioritization score of and a Public Health Impact score of 50%.
### Project Title: Community Care Transition Project (CCTP)

<table>
<thead>
<tr>
<th>Performing Provider Name: City of Houston Department of Health and Human Services</th>
<th>HDHHS -0937740-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 3 Outcome Measures:</td>
<td>0937740-08.3.16</td>
</tr>
<tr>
<td></td>
<td>Congestive Heart Failure 30 day readmission</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

#### Milestone 1 [P-X1]: Plan scope, range, and current capacity and needed resources for the CCTP.

**Metric 1: CCTP Program Planning Materials, Meeting minutes, Sign-in sheets, Logic Model, Draft Clinical Protocols, Staff Qualifications, Staffing Plan**

Goal: Produce a comprehensive document identifying results of planning and including information listed above.

Data Source: Report developed by project staff.

Milestone 1 Estimate Amount: $487,128.99

#### Milestone 2 [P-X2]: Develop and test Data systems

**Metric 1: Select, install and test data system**

Baseline/Goal: Install an efficient and effective data system to capture outcome and process data

Data Source: Documentation of installation of data system

Milestone 2 Estimate Amount: $368,672.47

#### Milestone 3 [P-4]. Milestone: Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge

**P-4.1 Metric: Care transitions assessment**

a. Submission of care transitions assessment and resource planning documents.

b. Data Source: Care transitions assessment and resource planning documents.

Milestone 3 Estimated Amount: $368,672.47

#### Milestone 4[P-2]. Milestone: Implement standardized care transition processes

**Metric: Care transitions policies and procedures; Submission of protocols**

a. Data Source: Policies and procedures of care transitions program materials

b. Data Source: Program Registry

Milestone 4 Estimated Amount: $1,208,631.06

#### Milestone 6 [I-11]: Improve the percentage of patients in defined population (at risk CHF) receiving standardized care according to the approved clinical protocols and care transitions policies

**I-11.1. Metric: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines**

a. Numerator: Number of at risk CHF patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines.

b. Denominator: Number of patients discharged or eligible for CCTP care transition services.

Data Source: Program Registry

Milestone 6 Estimated Amount: $1,162,511.11

#### Milestone 7 [I-11]: Improve the percentage of patients in defined population (at risk CHF) receiving standardized care according to the approved clinical protocols and care transitions policies

**I-11.1. Metric: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines**

a. Numerator: Number of at risk CHF patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines.

b. Denominator: Number of patients discharged or eligible for CCTP care transition services.

Data Source: Program Registry

Milestone 7 Estimated Amount: $1,162,511.11
<table>
<thead>
<tr>
<th>0937740-08.2.10</th>
<th>2.12.3</th>
<th>N/A</th>
<th>Project Title: Community Care Transition Project (CCTP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing Provider Name: City of Houston Department of Health and Human Services</td>
<td>HDHHS - 0937740-08</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measures:</strong></td>
<td>0937740-08.3.16</td>
<td>IT-3.2</td>
<td>Congestive Heart Failure 30 day readmission</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
</tbody>
</table>

Milestone 2 Estimate Amount: $487,128.99

Milestone 4 Estimated Amount: $368,672.47

**Milestone 5 [I-11].** Improve the percentage of patients in defined population (at risk CHF) receiving standardized care according to the approved clinical protocols and care transitions policies

I-11.1. Metric: Number of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines

Baseline: Establish baseline number of 30 individuals/month with CHF receiving the intervention.

Numerator: Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines.

Denominator: Number of patients
<table>
<thead>
<tr>
<th>0937740-08.2.10</th>
<th>2.12.3</th>
<th>N/A</th>
<th>Project Title: Community Care Transition Project (CCTP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing Provider Name: City of Houston Department of Health and Human Services</td>
<td>HDHHS -0937740-08</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measures:</strong></td>
<td>0937740-08.3.16</td>
<td>IT-3.2</td>
<td>Congestive Heart Failure 30 day readmission</td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong>&lt;br&gt;(10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>discharged or eligible for CCTP care transition services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Data Source: Registry</td>
<td>Data Source: Registry or EHR report/analysis</td>
<td>Milestone 5 Estimated Amount: $368,672.47</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $974,257.98</td>
<td>Year 3 Estimated Milestone Bundle Amount: $1,106,017.42</td>
<td>Year 4 Estimated Milestone Bundle Amount: $1,208,631.06</td>
<td>Year 5 Estimated Milestone Bundle Amount: $1,162,511.11</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $4,451,417</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
El Campo Memorial Hospital
Pass 1
Project Option 2.4.1 – Develop and implement a structured patient experience training program: Improving the Patient Experience – The AIDET Project.

**Unique RHP Project ID:** 131045004.2.1.  
**Performing Provider Name/TPI:** El Campo Memorial Hospital / 131045004

**Project Summary:**

Provider:
El Campo Memorial Hospital is a 30-bed rural hospital located in El Campo which is in Wharton County. The population of Wharton County is 41,280, and the community of El Campo has a population of 11,602 per the 2010 Census. El Campo Memorial Hospital provides the following services to the insured and uninsured population of Wharton County and surrounding areas: Medical & Surgical Inpatient stays, ICU stays, Swingbed stays, Operating Room, Day Surgery, Emergency Room, Radiology, Laboratory, Home Health, Rural Health Clinic, and Rehabilitation. El Campo Memorial Hospital provided approximately $2 million in charity care revenue in FY 2012.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions- 533</td>
<td>Self-Pay- 15%</td>
<td>Hispanic- 37%</td>
</tr>
<tr>
<td>Swingbed days- 706</td>
<td>Medicaid and CHIP- 7%</td>
<td>African American- 10%</td>
</tr>
<tr>
<td>Emergency visits- 5,626</td>
<td>Medicare- 46%</td>
<td>Caucasian- 31%</td>
</tr>
<tr>
<td>Outpatient visits- 11,568</td>
<td>Other Funding- 4%</td>
<td>Asian- 0.08%</td>
</tr>
<tr>
<td>Rural health clinic visits- 35,124</td>
<td>Commercial Insurance- 28%</td>
<td>Other- 21.92%</td>
</tr>
<tr>
<td>Home health visits- 1,604</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Intervention(s):**
The AIDET Project is a patient experience training program which was developed by the Studer Group. It is a powerful communication tool.

**Need for the project:**
The purpose of the project is to improve communication between patients and healthcare providers by enabling our employees with formal training of how to interact with patients to gain their trust which is essential for obtaining patient compliance and improving clinical outcomes.

**Target Population:**
All patients within the system with may benefit from this project (Medicaid and CHIP-7%/ Self-Pay- 15%).

**Category 1 or 2 expected patient benefits:**
By the end of DY3, our goal is for 90% of employees to have participated in the patient experience training. Our DY4 goal is to develop a display of patient experience data to share internally with employees the efforts we have undertaken to improve the experience of our patients and their families. Our DY5 goal is to share this patient experience data externally to our community.
Category 3 outcomes:
OD-6: Our goal is to increase patient satisfaction scores “To Be Determined” in DY4 and in DY5.
Project Option 2.4.1 – Develop and implement a structured patient experience training program: Improving the Patient Experience – The AIDET Project.

Unique RHP Project Identification Number: 131045004.2.1.
Performing Provider Name/TPI: El Campo Memorial Hospital / 131045004

Project Description:
El Campo Memorial Hospital will develop and implement a structured patient experience training program: Improving the Patient Experience – The AIDET Project.

El Campo Memorial Hospital is a 30-bed rural hospital located in Wharton County. The population of Wharton County is 41,280 per the 2010 Census. The community of El Campo has a population of 11,602 per the 2010 Census. El Campo Memorial Hospital is one of three top employers in El Campo who provide 200 jobs or more. El Campo Memorial Hospital is an acute hospital. We provide basic services including Emergency Room, Radiology, Laboratory, Rehabilitation, Swing Bed, Home Health and Hospice services. We also operate a hospital-based rural health clinic.

El Campo Memorial Hospital plans to roll out The AIDET Project to all new and existing full-time and part-time employees. The AIDET program was developed by the Studer Group. It is a powerful communication tool. AIDET is an acronym for Acknowledge, Introduce, Duration, Explanation and Thank You. When interacting with patients, gaining trust is essential for obtaining patient compliance and improving clinical outcomes. The project goal is to reduce patient anxiety and increase patient satisfaction which will result in positive outcomes for the patient.

We expect to incur scheduling difficulties amongst the targeted population; however, in addition to the live training program that will be conducted, we will also implement a self-study web-based program, so we can accommodate various schedules. By the end of the waiver, our expected outcome is to have 100% of our full-time and part-time employees trained on the patient experience training program, and for the employees and public to be educated on our efforts of improving patient satisfaction for our patients and their families. This project helps achieve the overall goals of the region by promoting positive healthcare experiences throughout the region which will ultimately improve the health of patients and decrease healthcare costs.

The goal of El Campo Memorial Hospital is to provide quality healthcare services to the communities of Wharton County and surrounding areas. Our goals align well with the Region 3 goals, as stated in the lead document, and this project focuses specifically to the goal of increasing access to primary care and specialty care services for the underserved populations regardless of their location or ability to pay. As a performing provider our goals also align with the regional goal of developing a culture of ongoing transformation & innovation as we will be heavily engaged in the Region 3 learning collaboratives specific to the outlined project.

The Medicaid population in Wharton County is approximately 8,300 clients, and there are an additional 7,616 persons living below the poverty level in Wharton County according to the Texas Department of State Health Services CY 2009 statistics. Furthermore, there is an additional 10,000 persons living in Wharton County without any health insurance. It is important that El Campo Memorial Hospital continue to reach out and provide services to these populations. In the last fiscal year, El Campo Memorial Hospital provided approximately 55,000 Outpatient Visits and approximately 3,000 Inpatient Days. El Campo Memorial Hospital
provides the following services to the insured and uninsured population of Wharton County and surrounding areas: Medical & Surgical Inpatient stays, ICU stays, Swingbed stays, Operating Room, Day Surgery, Emergency Room, Radiology, Laboratory, Home Health, Rural Health Clinic, and Rehabilitation.

Starting Point/Baseline:
The starting point/baseline for this project will be the number of new full-time and part-time employees and the number of existing full-time and part-time employees. As of October 1, 2012, we are expecting to train 134 full-time employees and 4 part-time employees. The number of new full-time and part-time employees is unknown at this time. The time period for this baseline is one year from October 1, 2012 – September 30, 2013; however, we will continue to provide patient experience training even after this date in order to continue our quality improvement process.

Rationale:
Our rationale for selecting project option 2.4.1 Implement processes to measure and improve patient experience was a result of the need for improved communication between patients and healthcare providers. We believe if we can increase patient satisfaction, it has the potential to increase the level of care integration and coordination of the patient/doctor relationship and lead to better health and better patient experience of care.

Project Components:
All core components will be addressed in this project:
   a) Organizational integration and prioritization of patient experience;
   b) Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience;
   c) Implementing processes to improve patient’s experience in getting through to the clinical practice; and
   d) Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures,

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
We believe the need for this project could fall under several of the needs reported in the RHP #3 Community Needs Assessment list, but it best is categorized under CN.23 Lack of patient navigation, patient and family education and information programs. If a patient has a good experience, we believe they will continue to actively engage themselves in their future health related care which will ultimately lead to positive outcomes and lower overall healthcare costs. We are not aware of any related activities to this project that are funded by the US. Department of Health and Human Services currently ongoing or coming up in the future.

Related Category 3 Outcome Measure(s):
OD-6 Percent improvement over baseline of patient satisfaction scores.
• IT-6.1 Percent Improvement Over Baseline Of Patient Satisfaction Scores

**Reasons/rationale for selecting the outcome measures:**
We believe if we can decrease patient anxiety and improve patient satisfaction in the rural setting when the patient is referred to the urban setting for extended/expanded healthcare that they will be more receptive and compliant to their healthcare needs which will ultimately lead to positive outcomes, improved patient satisfaction and ultimately lower healthcare costs. When patients perceive healthcare as a positive process, they will practice healthy lifestyles which results in lower healthcare costs.

We will focus on the stand-alone measure that will monitor an increase in patient satisfaction scores for the measure - patient is getting timely care, appointments, and information. We believe this measure is very important to the overall patient experience. These outcomes are important to our hospital because we believe if patients felt comfortable with the timeliness of their care, they would be less anxious about healthcare processes and more open to working with the healthcare providers. We believe by improving the patient experience through our Category 2 project – developing and implementing a structured patient experience training program, the patient will feel optimistic about their healthcare experience and take care of themselves. Again, we believe by focusing on patient satisfaction for every patient, it will improve the health of low-income population as well as the total population.

**Relationship to other Projects:** N/A

**Relationship to Other Performing Providers’ Projects in the RHP:**
Healthcare treatment cannot focus to only the acute or chronic encounter and properly treat the patient. It is critical that our region focuses to patient education and community education to ensure a proactive and responsive approach to healthcare needs. The education models represented in the Region 3 RHP plan can be identified in the Initiative Grid (addendum) and all focus to outcome measures such as appropriate utilization, patient satisfaction scores, and standalone chronic condition scores such as diabetes and asthma.

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

**Project Valuation:** We valued the project based on cost and benefits to our organization. We believe if we can reduce patient anxiety through education, the patient will have positive experiences and positive outcomes which will make them to want to take care of themselves by leading healthier lives, obtaining preventative healthcare and seeking medical help at appropriate times.
### Related Category 3 Outcome Measure(s): 131045004.3.1 IT-6.1(1)

**Percent improvement over baseline of patient satisfaction scores.**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-1]: Appoint an executive accountable for experience performance and create a percentage of time in existing executive positions for experience performance.</td>
<td><strong>Milestone 5</strong> [P-4]: Integrate patient experience training into new full-time and part-time employee orientation training.</td>
<td><strong>Milestone 8</strong> [P-6]: Include specific patient and/or employee experience objectives into employee job descriptions and work plans. Hold employees accountable for meeting them.</td>
<td><strong>Milestone 10</strong> [I-19]: Make patient experience data available externally (e.g., via a dashboard on the external website) and provide updates to the general public on the efforts the organization is undertaking to improve the experience of its patients and their families.</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-1.1]: Documentation of an executive assigned responsibility for experience performance. <strong>Goal</strong>: Appoint executive and dedicate time for existing positions <strong>Data Source</strong>: Job description</td>
<td><strong>Metric 1</strong> [P-4.1]: Percent of new full-time and part-time employees who received patient experience training as part of their new employee orientation. <strong>Baseline/Goal</strong>: Baseline = number of new full-time and part-time employees &amp; Goal = 90% of new full-time and part-time employees receive patient experience training. <strong>Data Source</strong>: Human Resource Records</td>
<td><strong>Metric 1</strong> [P-6.1]: Percent of employees who have specific patient and/or employee experience objectives in their job description and/or work plan. <strong>Baseline/Goal</strong>: Baseline = number of employees &amp; Goal = 100% employees to have specific patient and/or employee experience objectives in their job description and/or work plan. <strong>Data Source</strong>: Job descriptions</td>
<td><strong>Metric 1</strong> [I-19.1]: Number of external communications aimed at the general public’s understanding of the organization’s results and improvement efforts in the area of patient experience. <strong>Goal</strong>: TBD <strong>Data Source</strong>: External Communication</td>
</tr>
<tr>
<td><strong>Milestone 1 Estimated Incentive Payment</strong> (<em>maximum amount</em>): $44,857</td>
<td><strong>Milestone 5 Estimated Incentive Payment</strong> (<em>maximum amount</em>): $65,250</td>
<td><strong>Milestone 8 Estimated Incentive Payment</strong>: $98,160</td>
<td><strong>Milestone 10 Estimated Incentive Payment</strong>: $162,177</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-15]: Develop a training program on patient experience.</td>
<td><strong>Milestone 6</strong> [P-4]: Integrate patient experience training into existing full-time and part-time employee training.</td>
<td><strong>Milestone 9</strong> [I-18]: Develop regular organizational display(s) of patient experience data (e.g., via a dashboard on the internal web) and provide updates to the employees on the efforts the organization is undertaking to improve the experience of its patients and their families.</td>
<td><strong>Milestone 2 Estimated Incentive Payment</strong>: $44,858 <strong>Milestone 6 Estimated Incentive Payment</strong>: $50,000 <strong>Milestone 9 Estimated Incentive Payment</strong>: $98,160</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-15.1]: Submission of training program materials. <strong>Goal</strong>: Develop training program</td>
<td><strong>Metric 1</strong> [P-4.1]: Percent of existing full-time and part-time employees who received patient experience training. <strong>Baseline/Goal</strong>: Baseline = number of existing full-time and part-time employees &amp; Goal = 90% of</td>
<td><strong>Metric 1</strong> [I-18.1]: Number of data displayed and updates provided to employees <strong>Goal</strong>: TBD <strong>Data Source</strong>: Internal website and reports</td>
<td><strong>Milestone 2 Estimated Incentive Payment</strong>: $44,858 <strong>Milestone 6 Estimated Incentive Payment</strong>: $50,000 <strong>Milestone 9 Estimated Incentive Payment</strong>: $98,160</td>
</tr>
<tr>
<td><strong>Milestone 3</strong> [P-4]: Integrate patient experience training into new employee orientation training.</td>
<td><strong>Metric 1</strong> [P-4.1]: Percent of existing full-time and part-time employees who received patient experience training. <strong>Baseline/Goal</strong>: Baseline = number of existing full-time and part-time employees &amp; Goal = 90% of</td>
<td><strong>Milestone 3</strong> [I-18.1]: Number of employees who benefited from the organization’s efforts <strong>Goal</strong>: TBD <strong>Data Source</strong>: Employee survey</td>
<td><strong>Milestone 3 Estimated Incentive Payment</strong>: $44,858 <strong>Milestone 7 Estimated Incentive Payment</strong>: $50,000 <strong>Milestone 10 Estimated Incentive Payment</strong>: $98,160</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-4.1]: Percent of new full-time and part-time employees who received patient experience training. <strong>Baseline/Goal</strong>: Baseline = number of new full-time and part-time employees &amp; Goal = 90% of new full-time and part-time employees receive patient experience training. <strong>Data Source</strong>: Human Resource Records</td>
<td><strong>Milestone 7</strong> [P-6]: Integrate patient experience training into existing full-time and part-time employee training.</td>
<td><strong>Milestone 10 Estimated Incentive Payment</strong>: $162,177</td>
<td><strong>Milestone 7 Estimated Incentive Payment</strong>: $50,000</td>
</tr>
</tbody>
</table>
### IMPROVING THE PATIENT EXPERIENCE - THE AIDET PROJECT

**El Campo Memorial Hospital**

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Metric 1 [I-18.1]: Number of organization-wide displays (can be physical or virtual) about the organization’s performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Goal: TBD Data Source: Display and Internal Communication</th>
<th>Milestone 9 Estimated Incentive Payment: $98,159</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>131045004.3.1</strong> IT-6.1(1) Percent improvement over baseline of patient satisfaction scores.</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td><strong>Milestone 4 [P-4]: Integrate patient experience training into existing full-time and part-time employee training.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3 Estimated Incentive Payment (maximum amount):</strong> $44,858</td>
<td><strong>Milestone 6 Estimated Incentive Payment:</strong> $65,250</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $65,250</td>
<td><strong>Metric 1 [P-6.1]: Percent of employees who have specific patient and/or employee experience objectives in their job description and/or work plan.</strong> Baseline/Goal: Baseline = number of employees &amp; Goal = 100% of employees to have specific patient and/or employee experience objectives in their job description and/or work plan. Data Source: Job descriptions</td>
<td><strong>Goal:</strong> TBD</td>
<td><strong>Data Source:</strong> Job descriptions</td>
</tr>
<tr>
<td><strong>Metric 1 [P-4.1]: Percent of existing full-time and part-time employees who received patient experience training.</strong> Baseline/Goal: Baseline = number of existing full-time and part-time employees &amp; Goal = 50% of existing of full-time and part-time employees receive patient experience training. Data Source: Human Resource Records</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $65,250</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $65,250</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $65,250</td>
</tr>
<tr>
<td><strong>Milestone 4 Estimated Incentive Payment:</strong> $44,858</td>
<td><strong>Data Source:</strong> Human Resource Records</td>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $44,858</td>
<td><strong>Milestone 6 Estimated Incentive Payment:</strong> $65,250</td>
</tr>
<tr>
<td><strong>Baseline/Goal:</strong> Baseline = number of new full-time and part-time employees &amp; Goal = 75% of new full-time and part-time employees receive patient experience training. Data Source: Human Resource Records</td>
<td><strong>Milestone 6 Estimated Incentive Payment:</strong> $65,250</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $65,250</td>
<td><strong>Milestone 8 Estimated Incentive Payment:</strong> $98,159</td>
</tr>
<tr>
<td><strong>Milestone 3 Estimated Incentive Payment (maximum amount):</strong> $44,858</td>
<td><strong>Milestone 6 Estimated Incentive Payment:</strong> $65,250</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $65,250</td>
<td><strong>Milestone 8 Estimated Incentive Payment:</strong> $98,159</td>
</tr>
<tr>
<td><strong>Milestone 4 Estimated Incentive Payment:</strong> $44,858</td>
<td><strong>Milestone 6 Estimated Incentive Payment:</strong> $65,250</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $65,250</td>
<td><strong>Milestone 8 Estimated Incentive Payment:</strong> $98,159</td>
</tr>
<tr>
<td>131045004.2.1</td>
<td>2.4.1</td>
<td>2.4.1 (A-D)</td>
<td>IMPROVING THE PATIENT EXPERIENCE - THE AIDET PROJECT</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
<td>-------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td><strong>El Campo Memorial Hospital</strong></td>
<td></td>
<td></td>
<td>131045004</td>
</tr>
</tbody>
</table>

**Related Category 3 Outcome Measure(s):**
- 131045004.3.1
- IT-6.1(1)

**Percent improvement over baseline of patient satisfaction scores.**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $179,431</td>
<td>Year 3 Estimated Milestone Bundle Amount: $195,750</td>
<td>Year 4 Estimated Milestone Bundle Amount: $196,319</td>
<td>Year 5 Estimated Milestone Bundle Amount: $162,177</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5):* $733,677
Fort Bend County Clinical Health Services
Pass 1
Project Summary - Fort Bend County 2967606-01 2.1
Establish/Expand and Patient Care Navigation Program – Care Coordination Program

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

Intervention: This project will expand patient navigation services to a subset of the uninsured and underinsured population in the county which uses EMS and ED services inappropriately for non-emergent conditions and has no means to pay for the services. Identified patients will be referred into the navigation system to promote a medical home and provide primary care, prevention services and chronic condition management. In addition, linkages to social service agencies to resolve other issues will be provided. Navigation will include follow up for appointment and medication compliance.

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

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

Category 2 patient benefit milestones: The program targets a minimum of 95 individuals diverted from high cost EMS transportation and ED visits to the patient navigation system in the FQHC medical home.

Category 3 outcome measures: IT 1.10 – 10% (DY4) and 20% (DY5) reduction in HbA1c poor control (>9%) in the target population. IT 9.2 - 25% (DY4) and 30% (DY5) reduction in ED use in the target population. IT 9.4 - 15% (DY4) and 20% (DY5) reduction in EMS transport use in the target population.
Project Option 2.9.1 - Establish/expand a Patient Care Navigation Program: Care Coordination Program

Unique RHP Project Identification Number: 2967606-01 2.1
Performing Provider Name /TPI: Fort Bend County Clinical Health Services / 2967606-01

Project Description:

Fort Bend County proposes a project where Indigent Health Care, Medicaid and uninsured patients who are frequent or inappropriate users of the County Emergency Medical Service (EMS) and hospital Emergency Departments (EDs) or who have repeat admissions to the hospital would be referred into a care management system based in the local Federally Qualified Health Center.

- Care management would include:
  - Assistance with making and keeping outpatient appointments
  - Assistance with medication needs and medication compliance
  - Appropriate case management of chronic conditions
  - Dietary and exercise education
  - Transportation if needed
  - Connection to Social Service agencies for other needs
  - A call line to assist clients with determining whether they need EMS, ED or an appointment scheduled at the clinic.

The Care Management Program would be housed within the local Federally Qualified Health Center (FQHC), Fort Bend Family Health Center. This FQHC has in place the protocol to manage patients at the level of preventive care, for management of chronic conditions and outpatient acute illnesses. This project would enhance the capacity, the partnerships and the community connection to the protocol that has been developed. The FQHC would become the medical home for patients referred to and cared for at the facility.

A partnership of the local de facto indigent care hospital, the Federally Qualified Health Center, the Health Department, Emergency Medical Service, and additional community partners would collaborate on a systematic method of identifying frequent users of the high end medical resources who are covered by Medicaid, Medicare, or the County Indigent Health Care program or who are self-pay.

The identified clients would be referred into a care management program at the FQHC led by Community Health Workers. Fort Bend County Health & Human Services will subcontract with the FQHC to provide payment for clients referred by the program whose care is not covered by an insurance program and who cannot afford care. Community Health Workers will assume responsibility for contacting the referred individuals to establish a relationship, set appointments, and assist with medication compliance and encouragement for follow up visits to establish the FQHC as the medical home.

In addition to the Care Management program at the FQHC, Fort Bend County proposes to establish within the EMS department, an Advanced Practice Paramedic (APP) program that will allow for treatment at the home or scene of patients who are calling the 9-1-1 response service for non-emergent health needs. This program will be modeled after successful community primary care APP programs in the United Kingdom, Australia, Wake County, North Carolina and Tarrant County, Texas.
The aim is to provide necessary primary care on scene, avoid an expensive EMS transport and ED visit and also be the link in to the Care Management system at the Federally Qualified Health Center.

Target Zip codes for the program are:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>77053</td>
<td>77406</td>
<td>77407</td>
<td>77417</td>
<td>77441</td>
</tr>
<tr>
<td>77451</td>
<td>77459</td>
<td>77461</td>
<td>77464</td>
<td>77469</td>
</tr>
<tr>
<td>77476</td>
<td>77477</td>
<td>77478</td>
<td>77479</td>
<td>77481</td>
</tr>
<tr>
<td>77489</td>
<td>77494</td>
<td>77496</td>
<td>77497</td>
<td>77498</td>
</tr>
</tbody>
</table>

**Goals and Relationship to Regional Goals:**
The goal of this project is to provide a coordinated program of referrals, care management, patient centered needs resolution, community to medical home connection, and evaluation of program success in a rapid cycle improvement method. The proposed project will add community health worker capacity to the local FQHC and provide payment for services provided to those without means or coverage to pay. The goals include:

- Reduction in use of high end medical resources such as EMS and EDs
- Increase in the number of medically indigent, uninsured, and Medicaid eligible clients who have a medical home, prevention services and chronic disease management
- Improve clinical markers in the individuals served by the project.

The project meets the following regional goals:

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

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

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

**Starting Point/Baseline:**
Baseline data is not established, although each individual system has some data points as background rationale for the project. Data will be gathered on past and current users of the EMS system, hospital EDs and the Fort Bend County Indigent Care program for non-emergent and for frequent users of the high-end resources to establish the starting point for the proposed program.
In the first six months of the program, data gathering systems will be put in place to monitor the successful referral, engagement and outcomes for the patients who are referred in, using a rapid cycle improvement method.

**Rationale:**

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

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

Along with the use of expensive EMS and ED services for non-emergent illnesses, is the use of these same resources for chronic conditions which could better be managed and controlled in an outpatient setting using a medical home approach. Barriers to patients voluntarily seeking this option include lack of knowledge and understanding of their own medical conditions and of the resources available, lack of transportation, inability to pay fees and available hours for care.

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

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

**Project Components:**

**Required core project components: 2.9.1**

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.

c) Connect patients to primary and preventive care.

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.

e) Conduct quality improvement for project using methods such as rapid cycle improvement.
Other project components: 2.9.2
a) Development of an Advanced Practice Paramedic program to provide primary care in the community when individuals are attempting to use EMS and ED resources for non-emergent conditions and chronic condition stabilization.
b) Expand the available call line to allow all identified target population patients to access a community health worker and/or medical professional to assist with determining the level of care needed for a particular complaint – for example EMS and ED vs appointment at the medical home.

Milestones and Metrics:

**Process Milestones and Metrics**
P-1. Milestone: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. (Metric P-1.1)
P-3. Milestone: Provide care management/navigation services to targeted patients. (Metric P-3.1)
P-5. Milestone: Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. (Metric P-5.1)
P-8. Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. (Metric P-8.1)
P-X. Provide primary care to individuals with non emergent needs who call the 9-1-1 EMS for non-emergent conditions or chronic condition stabilization. (Metric P-X.1. Number served, P-X.2. Number referred to the Care Coordination Program)

**Improvement Milestones and Metrics**
I-7. Milestone: Reduce number of ED visits and/or avoidable hospitalizations for patients enrolled in the navigator program (Metric I-7.1)
I-8. Milestone: Reduction in ED use by identified ED frequent users receiving navigation services. (Metric I-8.1)
I-X. Milestone: Reduce number of EMS transports for patients enrolled in the patient navigator program (Metric I-X.1)

**Unique community need identification number the project addresses:**
CN.7 Insufficient access to care coordination practice management and integrated care treatment programs.
CN.8 High rates of inappropriate emergency department utilization
CN.9 High rates of preventable hospital admissions
CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease

**How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative.**
This project uses the care coordination protocol already in existence within the local FQHC and expands the scope of the protocol to include identified frequent or inappropriate users of the high cost resources of EMS transport services and ED visits. It additionally provides access to the care coordination protocol for those traditionally not involved in coordinated care.
systems which can lead to improved health outcomes and reduction in disease driven encounters with EMS and the ED.

This project will involve providing funding to the FQHC to expand the number of community health workers (patient navigators) available in order to handle the expected increase in the number of patients who utilize the FQHC as their medical home and to be available for hotline type calls to the FQHC. Federal funding will not be used to expand the number of staff involved in patient navigation related to this project.

**Related Category 3 Outcome Measures:**
OD-1 Primary and Chronic Disease Management (IT 1.10 – Diabetes Care)
OD-9 Right Care, Right Setting (IT 9.2 – ED Appropriate Utilization / Reduce ED use in target population referred to Care Coordination Program)
OD-9 Right Care, Right Setting (IT 9.4 – Other Outcome Improvement Target / Reduce EMS transport use in target population referred to Care Coordination Program)

a) Baseline measurement of rate of inappropriate transports in the target population
   a. Measured by review of EMS transport data during DY2 to determine payor source of non-emergent transports by Fort Bend County EMS
   b) Measurement of rate of inappropriate EMS transports in the referred population during DY3, DY4 and DY5
      a. Measured by review of EMS transport data during DY3, 4 and 5 to determine non-emergent transports by Fort Bend County EMS

**Reasons/Rationale for selecting the outcome measures:**
One population that could benefit from the proposed care coordination project is the indigent or uninsured population with a chronic health condition. This subset of the target population can indicate whether the chronic health condition is improved by coordination of care, management of medications, education, and having other needs met. For a chronic condition such as diabetes, the chosen improvement target is an easily recorded measure of the effectiveness of the program.

A determined need is to reduce the use of high cost medical resources such as ED and EMS for non-urgent and chronic conditions. The two additional outcome measures seek to determine whether the project is reaching this goal in the targeted population.

**Relationship to other Projects:** This project supports the Chronic Disease registry and interventions project proposed by our partners, the local hospital authority, and the FQHC. The intention of both projects is to decrease the burden of care on the EMS and emergency departments as well as to establish an improved coordination of care model for chronic and non-emergent conditions that will improve the health of the individuals involved, resulting in improved clinical outcomes and reduce the cost of care.

**Relationship to Other Performing Providers’ Projects in the RHP:**
The ability to properly identify and monitor specific patients with chronic conditions or frequent emergency department utilization trends will allow the region to accurately manage the very large patient base. Patient navigation includes a comprehensive list of tasks as well as unique provider types based on the focus of the initiative and will help the focus of cost containment, emergency department utilization, and chronic disease management. The Region 3 Initiative Grid in the addendum allows for a cross reference of all initiatives proposed within this concept.
**Plan for Learning Collaborative:** We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

**Project Valuation:**
This project addresses the top priority identified by the FBC 1115 Access to Care planning group – a system of Care Coordination for community residents who are medically indigent, uninsured or underinsured. The project aims to reduce EMS and ED use in this population, thereby improving the health of the targeted population by access to ongoing preventive and chronic disease care in a patient centered program as opposed to episodic disease care in high cost resource settings.

Valuation is based on cost avoidance, projecting savings associated with reducing unnecessary EMS and ED use by patients in the target population. Fort Bend County has analyzed cost data for patients in its indigent health care program. For this population, the cost of ED treatment averaged $3,000 for each of the 129 patients in one year. With a projected 25% reduction in ED visits the anticipated cost savings in one year is $96,750. Using the data for inpatient stays reduced by the project, the cost savings of 25% of the historic 295 inpatient hospital days ($1,400 per day) is $103,250. Adding to this is an anticipated 16.5% avoidance of EMS transports of the 4,161 medically unnecessary responses per year. At $800 cost per call, the yield is an anticipated $549,320 in savings. The total savings anticipated is $749,320 per year of the project.

References:
<table>
<thead>
<tr>
<th>Milestone 1 [P-1]: Conduct a Needs Assessment to identify the patient population(s) to be targeted with the Patient Navigator program.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1 [P-1.1]: Provide report identifying the following:</strong></td>
</tr>
<tr>
<td>Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy).</td>
</tr>
<tr>
<td>• Gaps in services and service needs.</td>
</tr>
<tr>
<td>• How program will identify, triage and manage target population (i.e. Policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts).</td>
</tr>
<tr>
<td>• Ideal number of patients targeted for enrollment in the patient navigation program</td>
</tr>
<tr>
<td>• Number of Patient Navigators needed to be hired</td>
</tr>
<tr>
<td>• Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required</td>
</tr>
<tr>
<td>Milestone 2 [P-3]: Provide care management/navigation services to targeted patients</td>
</tr>
<tr>
<td><strong>Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program</strong></td>
</tr>
<tr>
<td>Baseline: TBD</td>
</tr>
<tr>
<td>Goal: Successfully refer 50 patients (targeted population) from the ED or EMS to the Care Coordination program.</td>
</tr>
<tr>
<td>Data Source: Referral and enrollment reports</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $156,129</td>
</tr>
<tr>
<td>Milestone 3 [P-X]: Provide primary care to individuals with non emergent needs who call the 9-1-1 EMS for non-emergent needs or chronic disease stabilization using an Advanced Practice Paramedic program based in the EMS program.</td>
</tr>
<tr>
<td><strong>Metric 1 [P-X.1]: Number of patients referred to the Care Coordination program after receiving care</strong></td>
</tr>
<tr>
<td>Baseline: TBD</td>
</tr>
<tr>
<td>Goal: - Treat and refer 25 patients</td>
</tr>
<tr>
<td>Milestone 3 Estimated Incentive Payment: $173,350</td>
</tr>
<tr>
<td>Milestone 4 [P-X]: Provide Primary care to individuals with non emergent needs who call the 9-1-1 EMS for non-emergent needs or chronic disease stabilization using an Advanced Practice Paramedic program based in the EMS program.</td>
</tr>
<tr>
<td><strong>Metric 1 [P-X.1]: Number of patients referred to the Care Coordination program after receiving care</strong></td>
</tr>
<tr>
<td>Baseline: TBD</td>
</tr>
<tr>
<td>Goal: - Treat and refer 25 patients</td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment: $133,752</td>
</tr>
<tr>
<td>Milestone 5 [P-X]: Provide Primary care to individuals with non emergent needs who call the 9-1-1 EMS for non-emergent needs or chronic disease stabilization using an Advanced Practice Paramedic program based in the EMS program.</td>
</tr>
<tr>
<td><strong>Metric 1 [P-X.1]: Number of patients referred to the Care Coordination program after receiving care</strong></td>
</tr>
<tr>
<td>Baseline: TBD</td>
</tr>
<tr>
<td>Goal: - Treat and refer 25 patients</td>
</tr>
</tbody>
</table>

### Related Category 3

<table>
<thead>
<tr>
<th>Outcome Measure(s):</th>
<th>Diabetes Care: HbA1c Poor Control (&gt;9.0%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Appropriate Utilization</td>
<td></td>
</tr>
<tr>
<td>Other Outcome Improvement Target (Reduce EMS use)</td>
<td></td>
</tr>
</tbody>
</table>

### Table

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Milestone 6 [P-3]: Provide care management/navigation services to targeted patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program</strong></td>
</tr>
<tr>
<td>Baseline: (DY3 data) targeted patients referred in to system in DY3</td>
</tr>
<tr>
<td>Goal: increase the successfully referred patients (targeted population) by 50% over DY3 data from the ER or EMS to the Care Coordination program.</td>
</tr>
<tr>
<td>Data Source: Referral and enrollment reports</td>
</tr>
<tr>
<td>Milestone 6 Estimated Incentive Payment: $173,350</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 10 [P-3]: Provide care management/navigation services to targeted patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program</strong></td>
</tr>
<tr>
<td>Baseline: (DY4 data) targeted patients referred in to system in DY3</td>
</tr>
<tr>
<td>Goal: increase the successfully referred patients (targeted population) by 25% over DY4 data from the ER or EMS to the Care Coordination program.</td>
</tr>
<tr>
<td>Data Source: Referral and enrollment reports</td>
</tr>
<tr>
<td>Milestone 10 Estimated Incentive Payment: $133,752</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 11 [P-X]: Provide Primary care to individuals with non emergent needs who call the 9-1-1 EMS for non-emergent needs or chronic disease stabilization using an Advanced Practice Paramedic program based in the EMS program.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1 [P-X.1]: Number of patients referred to the Care Coordination program after receiving care</strong></td>
</tr>
<tr>
<td>Baseline: TBD</td>
</tr>
<tr>
<td>Goal: - Treat and refer 25 patients</td>
</tr>
</tbody>
</table>

### Regional Healthcare Partnership Plan

<p>| Region 3 | 1065 |</p>
<table>
<thead>
<tr>
<th>2967606-01 2.1</th>
<th>2.9.1</th>
<th>2.9.1(A-E)</th>
<th><strong>ESTABLISH/EXPAND A PATIENT NAVIGATION SYSTEM (CARE COORDINATION PROGRAM)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fort Bend County</strong></td>
<td><strong>2967606-01</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s):</strong></td>
<td><strong>Diabetes Care: HbA1c Poor Control (&gt;9.0%)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>2967606-01 3.2</strong></td>
<td><strong>IT 1.10</strong></td>
<td><strong>ED Appropriate Utilization</strong></td>
<td></td>
</tr>
<tr>
<td><strong>2967606.01 3.3</strong></td>
<td><strong>IT 9.2</strong></td>
<td><strong>Other Outcome Improvement Target (Reduce EMS use)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>2967606-10 3.4</strong></td>
<td><strong>IT 9.4</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
<tr>
<td><strong>Medical treatment, percentage of monolingual patients</strong></td>
<td><strong>to the Care Coordination program in DY3</strong></td>
<td><strong>referred to the Care Coordination program after receiving care</strong></td>
<td><strong>program after receiving care</strong></td>
</tr>
<tr>
<td><strong>Goal: To produce a report including the above data for program planning and implementation</strong></td>
<td><strong>Data Source: EMS APP program ePCR referral documentation</strong></td>
<td><strong>Baseline: No patients treated and referred by APP program in DY2</strong></td>
<td><strong>Baseline: No patients treated and referred by APP program in DY2</strong></td>
</tr>
<tr>
<td><strong>Data Source: Program documentation, EHR, claims, needs assessment survey, partner organization data</strong></td>
<td><strong>Milestone 3 Estimated Incentive Payment $156,128</strong></td>
<td><strong>Goal: Treat and refer 50 patients to the Care Coordination program in DY3</strong></td>
<td><strong>Goal: Treat and refer 75 patients to the Care Coordination program in DY3</strong></td>
</tr>
<tr>
<td><strong>Milestone 4:</strong> [P-5] Provide Reports on the types of navigation services provided to patients using the ED or EMS as high users or for episodic care</td>
<td><strong>Metric 1 [P-5.1] Collect and report on all the types of patient navigator services provided.</strong></td>
<td><strong>Milestone 7 Estimated Incentive Payment: $173,349</strong></td>
<td><strong>Milestone 11 Estimated Incentive Payment: $133,753</strong></td>
</tr>
<tr>
<td><strong>Baseline: Navigation Services not provided to this targeted and referred population in DY2</strong></td>
<td><strong>Data Source: Care Coordination CHW reports on referred patients</strong></td>
<td><strong>Goal: Comprehensive report on services provided</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Goal: Comprehensive report on services provided</strong></td>
<td><strong>Milestone 4 Estimated incentive Payment $156,128</strong></td>
<td><strong>Data Source: EMS APP program ePCR referral documentation</strong></td>
<td><strong>Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided.</strong></td>
</tr>
<tr>
<td><strong>Data Source: Care Coordination CHW reports on referred patients</strong></td>
<td><strong>Milestone 5:</strong> [P-8] Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to</td>
<td><strong>Milestone 8 Estimated incentive Payment $173,349</strong></td>
<td><strong>Baseline: Navigation Services not provided to this targeted and referred population in DY2</strong></td>
</tr>
<tr>
<td><strong>Baseline: Navigation Services not provided to this targeted and referred population in DY2</strong></td>
<td><strong>Milestone 5 Estimated incentive Payment $156,128</strong></td>
<td><strong>Goal: Comprehensive report on services provided</strong></td>
<td><strong>Goal: Comprehensive report on services provided</strong></td>
</tr>
<tr>
<td><strong>Goal: Comprehensive report on services provided</strong></td>
<td><strong>Milestone 8 Estimated incentive Payment $173,349</strong></td>
<td><strong>Data Source: Care Coordination CHW reports on referred patients</strong></td>
<td><strong>Data Source: Care Coordination CHW reports on referred patients</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided.</strong></td>
<td><strong>Milestone 11 Estimated Incentive Payment: $133,753</strong></td>
<td><strong>Milestone 12 Estimated incentive Payment $133,753</strong></td>
<td></td>
</tr>
<tr>
<td>2967606-01 2.1</td>
<td>2.9.1</td>
<td>2.9.1(a-e)</td>
<td>ESTABLISH/EXPAND A PATIENT NAVIGATION SYSTEM (CARE COORDINATION PROGRAM)</td>
</tr>
<tr>
<td>----------------</td>
<td>-------</td>
<td>------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Fort Bend County</strong></td>
<td></td>
<td></td>
<td><strong>2967606-01</strong></td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td></td>
<td></td>
<td><strong>Outcome Measure(s):</strong></td>
</tr>
<tr>
<td>2967606-01 3.2</td>
<td>IT 1.10</td>
<td>Diabetes Care: HbA1c Poor Control (&gt;9.0%)</td>
<td></td>
</tr>
<tr>
<td>2967606.01 3.3</td>
<td>IT 9.2</td>
<td>ED Appropriate Utilization</td>
<td></td>
</tr>
<tr>
<td>2967606-10 3.4</td>
<td>IT 9.4</td>
<td>Other Outcome Improvement Target (Reduce EMS use)</td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Measure(s):</strong></td>
<td></td>
<td></td>
<td><strong>Metric 1</strong></td>
</tr>
<tr>
<td>2967606-01 2.1</td>
<td></td>
<td></td>
<td><strong>Promote collaborative learning around shared or similar projects</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [P-8.1]:</strong></td>
<td></td>
<td></td>
<td><strong>Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</strong></td>
</tr>
<tr>
<td><strong>Goal:</strong></td>
<td></td>
<td></td>
<td><strong>Participate in all RHP organized meetings/seminars</strong></td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td></td>
<td></td>
<td><strong>Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes</strong></td>
</tr>
<tr>
<td><strong>Milestone 5 Estimated incentive Payment:</strong></td>
<td></td>
<td></td>
<td>$156,128</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td></td>
<td></td>
<td><strong>(10/1/2012 – 9/30/2013)</strong></td>
</tr>
<tr>
<td><strong>Year 3</strong></td>
<td></td>
<td></td>
<td><strong>(10/1/2013 – 9/30/2014)</strong></td>
</tr>
<tr>
<td><strong>Year 4</strong></td>
<td></td>
<td></td>
<td><strong>(10/1/2014 – 9/30/2015)</strong></td>
</tr>
<tr>
<td><strong>Year 5</strong></td>
<td></td>
<td></td>
<td><strong>(10/1/2015 – 9/30/2016)</strong></td>
</tr>
<tr>
<td><strong>Milestone 9:</strong></td>
<td></td>
<td></td>
<td><strong>Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [P-8.1]:</strong></td>
<td></td>
<td></td>
<td><strong>Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</strong></td>
</tr>
<tr>
<td><strong>Goal:</strong></td>
<td></td>
<td></td>
<td><strong>Participate in all RHP organized meetings/seminars</strong></td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td></td>
<td></td>
<td><strong>Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes</strong></td>
</tr>
<tr>
<td><strong>Milestone 9 Estimated incentive Payment:</strong></td>
<td></td>
<td></td>
<td>$173,349</td>
</tr>
<tr>
<td><strong>Milestone 9 Estimated incentive Payment:</strong></td>
<td></td>
<td></td>
<td>$173,349</td>
</tr>
<tr>
<td><strong>Milestone 13:</strong></td>
<td></td>
<td></td>
<td><strong>Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [P-8.1]:</strong></td>
<td></td>
<td></td>
<td><strong>Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</strong></td>
</tr>
<tr>
<td><strong>Goal:</strong></td>
<td></td>
<td></td>
<td><strong>Participate in all RHP organized meetings/seminars</strong></td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td></td>
<td></td>
<td><strong>Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes</strong></td>
</tr>
<tr>
<td><strong>Milestone 13 Estimated incentive Payment:</strong></td>
<td></td>
<td></td>
<td>$133,753</td>
</tr>
<tr>
<td><strong>Milestone 14 [I-9]:</strong></td>
<td></td>
<td></td>
<td><strong>Additional Outcome Metrics (improved diabetes control)</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [I-9.1]:</strong></td>
<td></td>
<td></td>
<td><strong>Improved Clinical outcome of target population (diabetes control HbA1c&lt;9.0%).</strong></td>
</tr>
<tr>
<td><strong>Baseline:</strong></td>
<td></td>
<td></td>
<td><strong>TBD determined for DY4</strong></td>
</tr>
<tr>
<td><strong>Goal:</strong></td>
<td></td>
<td></td>
<td><strong>10% improvement in diabetes control in population</strong></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>Fort Bend County</td>
<td>ESTABLISH/EXPAND A PATIENT NAVIGATION SYSTEM (CARE COORDINATION PROGRAM)</td>
<td>2967606-01</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------</td>
<td>------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2967606-01 2.1</th>
<th>2.9.1</th>
<th>2.9.1(A-E)</th>
<th>2967606-01</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Milestone 14 Estimated incentive Payment $133,753</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Outcome Measure(s):</th>
<th>Diabetes Care: HbA1c Poor Control (&gt;9.0%)</th>
<th>ED Appropriate Utilization</th>
<th>Other Outcome Improvement Target (Reduce EMS use)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>

- Year 2 Estimated Milestone Bundle Amount: $609,295
- Year 3 Estimated Milestone Bundle Amount: $624,513
- Year 4 Estimated Milestone Bundle Amount: $693,397
- Year 5 Estimated Milestone Bundle Amount: $668,764

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**

(add milestone bundle amounts over DYs 2-5): $2,595,969
Fort Bend County Clinical Health Services
Pass 2
Project Summary – Fort Bend County 2967606-01 2.2
Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: juvenile justice system - Behavioral Health Juvenile Diversion Project

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

Intervention: Fort Bend County (FBC) will design, implement and evaluate a program that diverts youth with complex behavioral health needs such as serious mental illness or a combination of mental illness and intellectual developmental disabilities, substance abuse and physical health issues from initial or further involvement with juvenile. Services are individualized and community based and include assessment, multi disciplinary treatment planning, crisis stabilization services, family supports, respite, specialized therapies (trauma focused interventions, cognitive behavioral interventions), medication management, case management and wraparound supports.

Need for the project: In the juvenile justice system the number of youth diagnosed with mental illness is significantly greater than that in the general population. Over the past decade, Fort Bend County Juvenile Probation Department has experienced a significant increase in the number of youth with mental health issues. A study completed by the Fort Bend Juvenile Probation Department (FBJPD) found that 18% to 20% of the youth in juvenile detention (between 2005 and 2009) were on psychotropic medication. The most recent data indicated that 40% to 45% of the youth in detention are on psychotropic medications. In 2011, Fort Bend Juvenile Probation Department completed 543 intakes/bookings on youth. It is estimated that approximately 40% of these youth had a mental illness.

Target population: The target population is youth with complex behavioral health needs such as serious mental illness or a combination of mental illness and intellectual developmental disabilities, substance abuse and physical health issues that are at risk of incarceration. The priority population will be the uninsured and Medicaid population.

Category 2 expected patient benefits: FBC expects to see a reduction in the percentage of youth with complex behavioral health needs that are incarcerated. The FBC project also expects to see an improvement in functioning of youth served by the FBC BHJ program. The FBC project will serve 10 youth in DY3, 20 youth in DY4 and 25 youth in DY5. It is expected that at least 20% of individuals receiving specialized interventions, through the FB BHJ project, will demonstrate improved functional status on standardized instruments in DY5.

Category 3 outcomes: IT 9.1 Reduce % (TBD) of admissions to juvenile detention for youth with complex behavioral health needs.
Category 2 Narrative

Identifying Project and Provider Information
Project Title: Fort Bend County Behavioral Health Juvenile Diversion Project

RHP Project Identification Number: 2967606-01 2.2
Performing Provider Center: Fort Bend County / 2967606-01
Project area: 2.13 - Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: juvenile justice system

Project Option: 2.13.1 – Design, implement and evaluate research supported and evidence based interventions tailored towards individuals in the target population: youth with complex behavioral health needs involved or at risk of involvement in the juvenile justice system.

Project Description: 2.13.1
Fort Bend County (FBC) proposes to develop a program that diverts youth with complex behavioral health needs such as serious mental illness or a combination of mental illness and intellectual developmental disabilities, substance abuse and physical health issues from initial or further involvement with juvenile and to support them in their communities. Services are individualized and community based and include assessment, multi disciplinary treatment planning, crisis stabilization services, family supports, respite, specialized therapies (trauma focused interventions, cognitive behavioral interventions), medication management, case management and wraparound supports.

In the juvenile justice system the number of youth diagnosed with mental illness is significantly greater than that in the general population. It is estimated that up to 70% of the youth in the juvenile justice system have at least one mental health disorder and approximately 20% have a serious mental illness\(^1\). There is agreement among both mental health and correction systems that many of these youth would be better served in community based programs with clinically appropriate interventions and supports.\(^2\) Youth with mental illness end up on the doorstep of juvenile justice system through a variety of different paths and the juvenile justice system, much like the criminal justice system, has become the default mental health treatment for youth.

In Fort Bend County, the lack of comprehensive and coordinated services for youth with serious mental illness has resulted in the juvenile probation department (including the detention facility) becoming the assessment, stabilization and even treatment center for many of these youth. The most recent Needs Assessment of FBC conducted by the Lyndon Baines Johnson School of Public Affairs in the summer of 2011 states that the lack of services for the mentally ill

---


has resulted in “mental health becoming a law enforcement issue.”3 The same study also indicated the scarcity of mental health services especially for the poor as a priority need for the county. Approximately, 9,000 persons are eligible for CHIP or Medicaid but not enrolled. Mental health services for youth, especially those with no insurance or on Medicaid, and with complex behavioral health needs is a significant need in Fort Bend County.

Over the past decade, Fort Bend County Probation Department has experienced a significant increase in the number of youth with mental health issues. Although the total number of juvenile cases has slightly decreased over the last several years, it is estimated that the number of cases involving mental health disorders, has nearly doubled. A study completed by the Fort Bend Juvenile Probation Department (FBJPD) found that 18% to 20% of the youth in juvenile detention (between 2005 and 2009) were on psychotropic medication. The most recent data obtained from FBJPD indicated that 40% to 45% of the youth in detention are on psychotropic medications. This increase is a direct result of a decrease in treatment services for youth at the community level, a decrease in inpatient treatment services, and the closing of several residential treatment centers in the Houston Metropolitan Area. Consequently, the juvenile justice system has become the default system for providing mental health services to youth. Unfortunately, this is often the start of a cycle with the criminal justice system leading into adulthood.

In 2011, Fort Bend Juvenile Probation Department completed 543 intakes/bookings on youth. It is estimated that approximately 40% of these youth have a mental illness. Many have co-occurring disorders of substance abuse. Furthermore, many struggle with learning disabilities, developmental disabilities, abuse and neglect, and poverty. These vulnerabilities coupled with family problems and legal involvement increase the odds for negative health outcomes.

The Fort Bend County (FBC) Behavioral Health Juvenile Diversion (BHJD) program will focus on the development of specialized interventions and a service delivery system to better identify youth with mental illness and divert them to the appropriate services. This project will interface other FBC proposed DSRIP projects including the Behavioral Health Crisis and Response system. The FBC BHJD program will enhance the safety net, provide necessary interventions, increase the array of services including diversion services, and as a result reduce incarceration of youth with serious mental illness and other complex behavioral health needs as well as improve the functional outcomes for these youth (as measured by the Child and Adolescents Needs and Strengths). The FBC BHJD will include cross systems training and development of data tracking systems to ensure the appropriate response to mental health needs of youth and to monitor outcomes.

The FBC BHJD program will provide intensive care coordination and assessment services at the first point of contact with law enforcement or other intercept point (e.g., schools, hospitals) to identify, triage, and divert youth to appropriate clinical services. The FB BHJD program will also

provide intensive care coordination to ensure that youth and their families are connected with the most appropriate level of clinical services in a timely manner. The FB BHJD will work collaboratively with treatment providers to develop individualized treatment plans that address the complex behavioral health needs of the youth and monitor treatment progress. Interventions such as Functional Family Therapy (FFT), Aggressive Replacement Training, Cognitive behavioral Therapy (CBT), respite, crisis stabilization services, and mentoring, wraparound supports may be part of the individualized treatment plans. Follow-up and aftercare services will be essential. As a result, the FBC BHJD program will work collaboratively with public and private behavioral health providers, FBC’s Health and Human Services, physical health providers, Mental Health America (MHA), National Alliance on Mental Illness (NAMI), and behavioral health providers and organizations in the community to provide the necessary array of services to divert youth from the incarceration and provide the necessary array of services to improve functional outcomes.

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

**Goals and Relationship to Regional Goals:**

**Project Goals**

FBC expects to see a reduction in the percentage of youth with complex behavioral health needs that are incarcerated. The FBC project also expects to see an improvement in functioning of youth served by the FBC BHJD program.

The FBC BHJD project presents a major opportunity to enhance the service delivery system for a complex behavioral health population (youth with serious mental illness at risk of involvement or further involvement with the legal system). The project also presents the opportunity for development of necessary infrastructure to facilitate communication, access, coordination, evaluation of services and systems transformation. The FBC project is the result of collaboration and commitment among county officials, law enforcement, health and human services, behavioral health (including the Mental Health Authority of Fort Bend County), courts, and community organizations to redesign current county operations to effectively respond to the behavioral health needs in the community.

**This project meets the following Region 3 goals:**

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

The FBC BHJD Program builds on the success of the FBC Juvenile Probation Department in providing an array of mental health services to youth involved in the juvenile system. The FB BHJD transforms the current service delivery system by expanding the array of services available, implementing and evaluating evidence based interventions, developing data tracking across systems, information sharing, and monitoring outcomes for a targeted population of youth with complex behavioral health needs at risk of involvement or further involvement in the juvenile justice system.

**Challenges:**
Access to appropriate levels of care will be a challenge. There are limited resources for stabilizing and supporting youth with behavioral health disorders in the community. The FBC project will address this by engaging with public and private providers of behavioral health services, community organizations, and volunteer groups. For example, FBC will work with MHA of FBC to develop an on-line resource directory with special attention to high risk populations (e.g., youth with complex behavioral health needs). This project will also focus on the expansion of wraparound supports and patient/ family education necessary for keeping youth in the community and development of strength/ protective factors.

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

**5-year Expected Outcome for Provider and Patients:**
FBC expects to see a reduction in the percentage of youth with behavioral health needs that are incarcerated and improved functional status. The project will be county wide and include the following zip codes:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>77053</td>
<td>77406</td>
<td>77407</td>
<td>77417</td>
<td>77441</td>
</tr>
<tr>
<td>77451</td>
<td>77459</td>
<td>77461</td>
<td>77464</td>
<td>77469</td>
</tr>
<tr>
<td>77476</td>
<td>77477</td>
<td>77478</td>
<td>77479</td>
<td>77481</td>
</tr>
<tr>
<td>77489</td>
<td>77494</td>
<td>77496</td>
<td>77497</td>
<td>77498</td>
</tr>
</tbody>
</table>

**Starting Point/Baseline:**
This is a new program; therefore, the baseline for all metrics and milestones will be established after the project is implemented.
**Rationale:**
**Reasons for selecting the project option:** 2.13.1 – Design, implement and evaluate research supported and evidence based interventions tailored towards individuals in the target population: youth with complex behavioral health needs involved or at risk of involvement in the juvenile justice system.

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

a. Assess size, characteristics and needs of target population
   FBC BHJD project will expand the assessment of the needs of youth with severe mental illness as well as the factors leading to their involvement with law enforcement.

b. Review literature/ experiences with populations similar to the target population to determine community based interventions that are effective at diverting youth from the incarceration.
   FBC BHJD project will continue to review literature and evaluate ongoing experiences with youth with complex behavioral health needs that are effective at reducing negative outcomes, such as incarceration, decreased mental and physical functional status and promoting positive health, social and quality of life outcomes.

c. Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.
   FBC BHJD project will develop a project evaluation plan that includes qualitative and quantitative measures to determine project outcomes.

d. Design models which include an appropriate range of community based and residential supports.
   FBC BHJD project will work with public and private behavioral health providers, community organizations, and others stakeholders to develop an array of community based services for youth with complex behavioral health.

e. Assess the impact of the interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.
   FBC BHJD will develop measurement processes that are based on standardized tools relevant to the target population including the use of the Child and Adolescent Needs and Strengths (CANS).

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

- P-1 – Conduct needs assessments of youth with complex behavioral health needs
- P-2 - Design community based specialized interventions for youth to prevent incarceration or re-incarceration and improve functional status
- P-3 – Enroll and serve individuals
- P-4 – Evaluate and continuously improve interventions
P-7– Participate in face-to-face learning (i.e., meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around similar or shared projects.

Since this is a start-up project and these services are not available, all of these milestones/metrics are necessary for a successful project.

The following improvement milestone and metrics were chosen.

1-5.1 : 10% of individuals receiving specialized interventions, through the FB BHJD project, will demonstrate improved functional status on standardized instruments (e.g., CANS) in DY4 and 20% in DY5

The Child and Adolescent Needs and Strengths Assessment (CANS) will be used to guide service planning and to evaluate functional status. The CANS will be completed at intake and at regular intervals throughout the project to guide service planning. The CANS post intervention data will be used as an improvement outcome.

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

This is a new initiative for FBC and will improve response to youth with complex behavioral health needs that are involved with juvenile probation department and / or at risk of involvement. In addition, this initiative will further the development of needed infrastructures and partnerships to leverage existing resources, develop additional resources based on identified needs, and improve access to care in the community.

Related Category 3 Outcome Measure(s):
The Category 3 Outcome Measure chosen falls within OD-9-Right Care, Right Setting.

Reasons/rationale for selecting the outcome measure(s):
The goal of the FBC project is to divert youth with complex behavioral health needs from incarceration. The Fort Bend County (FBC) Behavioral Health Juvenile Diversion (BHJD) program will focus on the development of specialized interventions and a service delivery system to better identify youth with mental illness and divert them to the appropriate services. This project will interface other FBC proposed DSRIP projects including the Behavioral Health Crisis and Response system. The FBC BHJD program will provide necessary interventions, increase the array of services including diversion services, and as a result reduce incarceration of youth with serious mental illness and other complex behavioral health needs as well as improve the functional outcomes for these youth.

Relationship to Other Projects:
This project will interface with the Behavioral Health Crisis Response and Intervention project proposed by FBC. The project will also interface with the FBC Primary Care Coordination and Primary Care Expansion projects to facilitate access to essential primary care often overlooked for youth with behavioral health disorders.
Relationship to Other Performing Providers’ Projects in the RHP: The FBC project will interface with other Performing Provider’s (PP’s) in the region to ensure access to necessary behavioral health services to prevent juvenile justice involvement and improve functional status of youth with complex behavioral health needs.

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

Project Valuation: Valuation is based on cost avoidance, projecting savings associated with reducing use of Juvenile Detention to manage the target population with regard to mental and behavioral health needs. During DY 4 and DY 5 Fort Bend County will avoid an average of 41 days annually in detention for an average of 23 youth per year. At $400 per day, this will produce a total savings of $754,400.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measures</th>
<th>2967606-01 3.5</th>
<th>IT-9-1</th>
<th>Decrease in mental health admissions and readmissions to criminal justice settings (juvenile detention)</th>
</tr>
</thead>
</table>

Starting Point/Baseline: TBD

| Year 2  
(10/1/2012 – 9/30/2013) | Year 3  
(10/1/2013 – 9/30/2014) | Year 4  
(10/1/2014 – 9/30/2015) | Year 5  
(10/1/2015 – 9/30/2016) |
|---------------------------|---------------------------|---------------------------|---------------------------|
| P-1 Conduct needs assessment  
Metric 1 (P-1.1): Numbers of individuals, demographics, location, diagnoses, educational needs, family, natural supports, functional issues, juvenile justice and psychiatric needs  
Data Source: Project documentation; law enforcement records; public psychiatric facility records; survey of stakeholders (e.g., inpatient providers, mental health providers, social services, family, and forensics)  
Process Milestone Estimated Incentive Payment: $146,751 | P-2 Design community-based specialized interventions to prevent incarceration and improve functional status  
Metric 2 (P-2.1): Project plans will be based on empirically based treatment approaches such as those offered by SAMSHA  
Data Source: Written Plan  
Goal: Complete project plan  
Process Milestone Estimated Incentive Payment: $82,351 | P-3 Enroll and Serve individuals  
Metric 2 (P-3.1): Number of targeted individuals enrolled  
Data Source: Project reports  
Goal: Enroll and serve 20 youth  
Process Milestone Estimated Incentive Payment: $59,410 | P-3 Enroll and Serve individuals  
Metric 8 (P-3.1): Number of targeted individuals enrolled  
Data Source: Project reports  
Goal: Enroll and serve 25 youth  
Process Milestone Estimated Incentive Payment: $57,198 |
<table>
<thead>
<tr>
<th>2967606-01 2.2</th>
<th>2.13.1 (A) –(E)</th>
<th>Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: juvenile justice system</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fort Bend County</strong></td>
<td>2967606-01</td>
<td><strong>IT-9-1</strong> Decrease in mental health admissions and readmissions to criminal justice settings (juvenile detention)</td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measures</strong></td>
<td>2967606-01 3.5</td>
<td><strong>TBD</strong></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>TBD</strong></td>
<td><strong>TBD</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>P-3</strong> Enroll and Serve individuals</td>
<td><strong>P-7</strong> – Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around similar/shared projects. <strong>Metric(P-7.1):</strong> Participate in semi-annual face-to-face meetings or seminars organized by the RHP. <strong>Baseline/Goal (P-7.1):</strong> Promote continuous learning and best practices in twice-yearly meetings. <strong>Data Source (P-7.1):</strong> Documentation of semiannual face-to-face meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
</tr>
<tr>
<td><strong>Process Milestone</strong></td>
<td><strong>Incentive Payment:</strong> $82,350</td>
<td><strong>Incentive Payment:</strong> $59,410</td>
</tr>
<tr>
<td><strong>Metric 2 (P-3.1):</strong> Number of targeted individuals enrolled</td>
<td><strong>Goal:</strong> Enroll and serve 10 youth</td>
<td><strong>Data Source (P-7.1):</strong> Documentation of semiannual face-to-face meetings including meeting agendas, slides from presentations, and/or meeting notes. <strong>Process Milestone Estimated Incentive Payment:</strong> $57,198</td>
</tr>
</tbody>
</table>
Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: juvenile justice system

<table>
<thead>
<tr>
<th>Fort Bend County</th>
<th>2967606-01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 3 Outcome Measures</td>
<td>2967606-01</td>
</tr>
<tr>
<td>3.5</td>
<td>IT-9-1</td>
</tr>
<tr>
<td>Decrease in mental health admissions and readmissions to criminal justice settings (juvenile detention)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Improvement Milestone:**
- **Milestone:** Functional Status
- **1-5.1. Metric:** 10% percent of individuals receiving specialized interventions demonstrate improved functional status on standardized instruments (e.g., CANS, etc.)
- **Data Source:** standardized instruments (e.g., CANS, etc.)

**Outcome Improvement Target Estimated Incentive:** $59,409

**Improvement Milestone:**
- **Milestone:** Functional Status
- **1-5.1. Metric:** 20% percent of individuals receiving specialized interventions demonstrate improved functional status on standardized instruments (e.g., CANS, etc.)
- **Data Source:** standardized instruments (e.g., CANS, etc.)

**Outcome Improvement Target Estimated Incentive:** $57,197

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $146,751

**Year 3 Estimated Milestone Bundle Amount:** $164,701

**Year 4 Estimated Milestone Bundle Amount:** $178,229

**Year 5 Estimated Milestone Bundle Amount:** $171,593

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over DYs 2-5): $661,274
Project Summary - Fort Bend County 2967606-01 2.3
Redesign Primary Care – Community Paramedic Program

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

Intervention: This project will provide primary care to individuals who call 9-1-1 service for non-emergent conditions. Advanced Practice Paramedics will assess the individuals, provide necessary care and also connect them to the local Federally Qualified Health Center (FWHC) and the patient navigation program proposed in our project 2967606-01 2.1. The project will promote the medical home and serve as a community based navigation system.

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

Target Population: Uninsured, underinsured or Medicaid covered individuals who do not access primary care and use emergency services in lieu of a medical home. Patients will receive primary or acute care in their home setting and will then receive the benefit of ongoing assistance with medical care for primary prevention and chronic conditions as well as being linked to needed social services and transportation. Overall health will improve as well as some of the conditions leading to less than optimum health.

Category 2 patient benefit milestones: The program targets a minimum of 225 individuals diverted from high cost EMS transportation and ED visits to the FQHC medical home.

Category 3 outcome measures: IT 9.2 – 25% reduction in ED use in DY 4 and 30% reduction in DY5 in the target population. IT 9.4 - 25% reduction in EMS transport use in DY 4 and 30% reduction in DY5 in the target population.
Project Option 2.3.2: “Other” project option: Implement other evidence-based project to redesign primary- Community Paramedic Program

Unique RHP Project Identification Number: 2967606-01 2.3 / Pass 2
Performing Provider Name /TPI: Fort Bend County Clinical Health Services / 2967606-01

Project Description:

Fort Bend County proposes a project which would identify Indigent Health Care, Medicaid and uninsured patients who are frequent or inappropriate users of the County Emergency Medical Service (EMS) and hospital Emergency Departments (EDs) to provide appropriate care in their home setting using Advanced Practice Paramedics / Community Paramedics. The project will have the following components:

- EMS Dispatch trained to determine nature of call as non-emergent
- Trained Advanced Practice Paramedics / Community Paramedics
- Response vehicles with equipment for treatment at home, but not ALS transport
- Treatment of minor or chronic illness in the home setting
- Transportation to a medical facility if determined necessary
- Coordination with the established medical home for the target population, the FQHC for ongoing management of chronic conditions, primary care, prevention services
- Connection to Social Service agencies for other needs
- Information provide on the call line to assist clients with determining whether they need EMS, ED or an appointment scheduled at the FQHC clinic.

The Community Paramedic Program would be housed with the Fort Bend County EMS department, which is part of Fort Bend County Health & Human Services. The program would be conducted in coordination with the local Federally Qualified Health Center (FQHC), AccessHealth. The FQHC would become the medical home for patients referred after treatment by the Community Paramedic Program.

A partnership of the local de facto indigent care hospital, the Federally Qualified Health Center, the Health Department, Emergency Medical Service, and additional community partners would collaborate on a systematic method of identifying frequent users of the high end medical resources who are covered by Medicaid, Medicare, or the County Indigent Health Care program or who are self-pay. These patients would be eligible for management through the Community Paramedic Program. This program will be modeled after successful community primary care APP programs in the United Kingdom, Australia, Wake County, North Carolina and Tarrant County, Texas.

The aim is to provide necessary primary care on scene, avoid an expensive EMS transport and ED visit and also be the link in to the Care Management system at the Federally Qualified Health Center. As reported by other programs established in communities, the program can reduce the probability of providing acute emergency medical care for at risk patients and the medically underserved, thereby reducing unnecessary health care expenditures, and increase the outreach activity and education components of EMS.

Target Zip codes for the program are:

<table>
<thead>
<tr>
<th>77053</th>
<th>77406</th>
<th>77407</th>
<th>77417</th>
<th>77441</th>
<th>77444</th>
</tr>
</thead>
<tbody>
<tr>
<td>77451</td>
<td>77459</td>
<td>77461</td>
<td>77464</td>
<td>77469</td>
<td>77471</td>
</tr>
</tbody>
</table>
Goals and Relationship to Regional Goals:
The goal of this project is to provide a coordinated program of patient centered needs resolution, community to medical home connection, and evaluation of program success in a rapid cycle improvement method. The proposed project will add Advanced Practice Paramedics to the local EMS. The goals include:

- Reduction in use of high end medical resources such as EMS and EDs
- Increase in the number of medically indigent, uninsured, and Medicaid eligible clients who have access to primary care and a medical home, prevention services and chronic disease management
- Improvement in health for those patients who are identified as frequent users of high end resources for non-emergent care.

The project meets the following regional goals:

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

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

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

Starting Point/Baseline:
Baseline data is not established, although the EMS and EDs have some data points as background rationale for the project. Data will be gathered on past and current users of the EMS system, hospital EDs and the Fort Bend County Indigent Care program for non-emergent and for frequent users of the high-end resources to establish the starting point for the proposed program. In the first six months of the program, data gathering systems will be put in place to monitor the successful treatment, referral, engagement and outcomes for the patients who are referred in, using a rapid cycle improvement method.
Rationale:
Reasons for selecting the project option:

Fort Bend County does not have a hospital district structure for indigent healthcare or for the uninsured and underinsured population of the County. The County participates in the state mandated Indigent Health Care Program which provides care for qualifying individuals whose income is below 22% of the Federal Poverty Level. With a population estimate of 606,000, there are more than 48,500 (8%) individuals living below the Federal Poverty Level and up to 115,140 uninsured at this time in the County¹. For these individuals, medical care is often beyond their economic reach. Cash payment options and even sliding scale fees take lower priority than housing payments and food. One of the ways that the indigent population of the County avoids payment up front is to utilize the EMS 9-1-1 response system to obtain a “free” ride to the hospital, to receive priority care in the Emergency Department because of EMS transport and to not have a co-pay on site at the hospital.

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

Along with the use of expensive EMS and ED services for non-emergent illnesses, is the use of these same resources for chronic conditions which could better be managed and controlled in an outpatient setting and using a medical home approach. Barriers to patients voluntarily seeking this option include lack of knowledge and understanding of their own medical conditions and of the resources available, lack of transportation, inability to pay fees and available hours for care.

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

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

Project Components:
Project option 2.3.2 does not have required components. Other project components:

1. Development of an Advanced Practice Paramedic/Community Paramedic program to provide primary care in the community when individuals are attempting to use EMS and ED resources for non-emergent conditions and chronic condition stabilization.

2. Ensure coordination of the Community Paramedic Program with the FQHC and Social Service agencies within the community to allow for ongoing coordination of care and resolution of other needs.

Milestones and Metrics:
Process Milestones and Metrics
P-X. Milestone: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. (Metric P-X.1)
P-XX. Milestone: Provide primary care to individuals with non emergent needs who call the 9-1-1 EMS for non-emergent conditions or chronic condition stabilization, and referral services to the targeted patients. (Metric P-XX.1)
P-XXX. Milestone: Provide reports on the types of care provided to patients using the Community Paramedic Program. (Metric P-XXX.1)
P-12. Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. (Metric P-12.1)

Improvement Milestones and Metrics
I-X. Milestone: Reduce number of EMS transports for patients managed by the Community Paramedic Program (Metric I-X.1)
I-XX. Milestone: Reduce the number of inappropriate ED visits for patients managed by the Community Paramedic Program. (Metric I-XX.1)

Unique community need identification number the project addresses:
- CN.8 High rates of inappropriate emergency department utilization
- CN.9 High rates of preventable hospital admissions
- CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease
- CN.21 Inadequate transportation options for individuals in rural areas and for indigent/low income populations

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
This project uses a proven community paramedic program concept to reduce the burden on over utilized high end resources such as EMS transport and ED care, while offering primary and chronic care management in the home setting. The project also brings patients into a care coordination system and medical home for ongoing management which can lead to improved health outcomes and reduction in episodic and disease driven encounters with EMS and the ED.

Related Category 3 Outcome Measures:
OD-9 Right Care, Right Setting (IT 9.2 – ED Appropriate Utilization / Reduce ED use in target population managed by the Community Paramedic Program)
OD-9 Right Care, Right Setting (IT 9.4 – Other Outcome Improvement Target / Reduce EMS transport use in target population managed by the Community Paramedic Program)

Reasons/Rationale for selecting the outcome measures:
The population that will benefit from the proposed Community Paramedic Program is the indigent or uninsured population with episodic or chronic health conditions. A determined need is to reduce the use of high cost medical resources such as ED and EMS for non-urgent and chronic conditions. The two outcome measures seek to determine whether the project is reaching this goal in the targeted population.
Relationship to other Projects: This project supports the Chronic Disease registry ED diversion projects proposed by our partners, the local hospital authority, and the FQHC. In addition, it will support the Care Coordination project proposed in the Pass One submission by Fort Bend County. The intention of each of these projects is to decrease the burden of care on the EMS and emergency departments as well as to establish an improved coordination of care model for chronic and non-emergent conditions that will improve the health of the individuals involved, resulting in improved clinical outcomes and reduce the cost of care.

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

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

Project Valuation: This project addresses the top priority identified by the FBC 1115 Access to Care planning group – a system of care for community residents who are medically indigent, uninsured or underinsured. The project aims to reduce EMS and ED use in this population, thereby improving the health of the targeted population by access to ongoing preventive and chronic disease care in a patient centered program as opposed to episodic disease care in high cost resource settings.

Valuation is based on cost avoidance, projecting savings associated with reducing unnecessary EMS and ED use by patients in the target population. Fort Bend County will reduce EMS and emergency room usage during DY 4 and DY 5 by an estimated $1.5 million.

References:
2. BMJ 207; 335 doi: 10.1136/bmj.39356.700139.BE (Published 1 November 2007)
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Milestone 1** [P-X]: Conduct a Needs Assessment to identify the patient population(s) to be targeted with the Community Paramedic Program.  
**Metric 1** [P-1.1]: Provide report identifying the following:  
- Targeted patient population characteristics (e.g., patients with frequent ED utilization, insurance status, low health literacy).  
- Gaps in services and service needs.  
- How program will identify, triage and manage target population (i.e. Policies and procedures, referral protocols/ algorithms, service maps or flowcharts).  
- Ideal number of patients targeted  
- Number of APP needed  
Goal: To produce a report including the above data for program planning and implementation  
Data Source: Program documentation, ePCR, EHR, claims, needs assessment survey, partner organization data  
Data Source: Written report  
Milestone 1 Estimated Incentive Payment: $146,751 | **Milestone 2** [P-XX]: Provide care through a Community Paramedic Program to targeted patients  
**Metric 1** [P-XX.1]: Increase in the number of targeted patients served by the program in the program  
Baseline: TBD  
Goal: Successfully treat 50 patients (targeted population) using a community paramedic program.  
Data Source: Usage and Care reports  
Milestone 2 Estimated Incentive Payment: $54,901 | **Milestone 5** [P-XX]: Provide care through a Community Paramedic Program to targeted patients  
**Metric 1** [P-XX.1]: Increase in the number of targeted patients served by the program in the program  
Baseline: DY3  
Goal: Successfully treat 75 patients (targeted population) using a community paramedic program.  
Data Source: Usage and Care reports  
Milestone 5 Estimated Incentive Payment: $59,410 | **Milestone 8** [P-XX]: Provide care through a Community Paramedic Program to targeted patients  
**Metric 1** [P-XX.1]: Increase in the number of targeted patients served by the program in the program  
Baseline: DY3  
Goal: Successfully treat 100 patients (targeted population) using a community paramedic program.  
Data Source: Usage and Care reports  
Milestone 8 Estimated Incentive Payment: $42,898 |

| **Milestone 3** [P-XXX]: Provide Reports on the types of care and referrals provided to patients using the Community Paramedic Program  
**Metric 1** [P-XXX.1]: Collect and report on all the patients encountered by the Community Paramedic Program.  
Baseline: TBD from DY3 data  
Goal: Comprehensive report on services provided  
Data Source: ePCR, EHR, dispatch reports | **Milestone 6** [P-XXX]: Provide Reports on the types of care and referrals provided to patients using the Community Paramedic Program  
**Metric 1** [P-XXX.1]: Collect and report on all the patients encountered by the Community Paramedic Program.  
Baseline: TBD from DY3 data  
Goal: Comprehensive report on services provided  
Data Source: ePCR, EHR, dispatch reports | **Milestone 9** [P-XXX]: Provide Reports on the types of care and referrals provided to patients using the Community Paramedic Program  
**Metric 1** [P-XXX.1]: Collect and report on all the patients encountered by the Community Paramedic Program.  
Baseline: TBD from DY3 data  
Goal: Comprehensive report on services provided  
Data Source: ePCR, EHR, dispatch reports | **Milestone 10** [P-XXX]: Provide Reports on the types of care and referrals provided to patients using the Community Paramedic Program  
**Metric 1** [P-XXX.1]: Collect and report on all the patients encountered by the Community Paramedic Program.  
Baseline: TBD from DY3 data  
Goal: Comprehensive report on services provided  
Data Source: ePCR, EHR, dispatch reports |
| 2967606-01 2.3 | 2.3.2 | N/A | **REDESIGN PRIMARY CARE**  
**ESTABLISH A COMMUNITY PARAMEDIC PROGRAM** |
|----------------|-------|-----|------------------------------------------------------------------|
| **Fort Bend County** | **2967606-01** | | **Outcome Measure(s):**  
2967606-01 3.6  
2967606-01 3.7 | **IT I.X**  
**IT I.XX** | **REDUCE NUMBER OF INAPPROPRIATE EMS TRANSPORTS**  
**REDUCE THE NUMBER OF INAPPROPRIATE ED VISITS** |

| **Year 2**  
(10/1/2012 – 9/30/2013) | **Year 3**  
(10/1/2013 – 9/30/2014) | **Year 4**  
(10/1/2014 – 9/30/2015) | **Year 5**  
(10/1/2015 – 9/30/2016) |
|-------------------------|-------------------------|-------------------------|-------------------------|
| Milestone 3 Estimated incentive  
Payment $54,900 | | Milestone 6 Estimated incentive  
Payment $59,410 | Milestone 9 Estimated incentive  
Payment $42,898 |
| **Milestone 4** [P-12]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects | | **Milestone 7** [P-12]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects | **Milestone 10** [P-12]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects |
| Metric 1 [P-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.  
Goal: Participate in all RHP organized meetings/seminars  
Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes | | Metric 1 [P-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.  
Goal: Participate in all RHP organized meetings/seminars  
Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes | Metric 1 [P-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.  
Goal: Participate in all RHP organized meetings/seminars  
Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes |
| Milestone 4 Estimated incentive  
Payment $54,900 | | Milestone 7 Estimated incentive  
Payment $59,409 | Milestone 10 Estimated incentive  
Payment $42,898 |
| **Milestone 12** [I-X]: Successful primary care/episodic care given to target population with referral to the medical home.  
**Metric 1** [I-X.1]: Care given to Target Population  
Baseline: TBD determined in DY3 | | | |
| 2967606-01 2.3 | 2.3.2 | N/A | **REDESIGN PRIMARY CARE**  
**ESTABLISH A COMMUNITY PARAMEDIC PROGRAM**  
Fort Bend County | 2967606-01 |
|---|---|---|---|
| **Related Category 3**  
**Outcome Measure(s):** | 2967606-01 3.6  
2967606-01 3.7 | IT I.X  
IT I.XX | REDUCE NUMBER OF INAPPROPRIATE EMS TRANSPORTS  
REDUCE THE NUMBER OF INAPPROPRIATE ED VISITS |
| **Year 2**  
(10/1/2012 – 9/30/2013) | **Year 3**  
(10/1/2013 – 9/30/2014) | **Year 4**  
(10/1/2014 – 9/30/2015) | **Year 5**  
(10/1/2015 – 9/30/2016) |
| Goal: Successful treatment of 25% of all non-emergent calls in the target population in the home/call location setting.  
Data Source: ePCR, call logs | Milestone 12 Estimated incentive Payment $42,898 | Year 2 Estimated Milestone Bundle Amount: $146,751  
Year 3 Estimated Milestone Bundle Amount: $164,701  
Year 4 Estimated Milestone Bundle Amount: $178,229  
Year 5 Estimated Milestone Bundle Amount: $171,593 |
| **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over DYS 2-5): $661,274 |  |  |  |
Project Option 2.7.1: Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations– Colonoscopy Screening

Unique RHP Project ID: 2967606-01 2.4 / Pass 2
Performing Provider Name/TPI: Fort Bend County Clinical Health Services/2967606-01

Project Description:
Fort Bend County proposes a project where Indigent Health Care, Medicaid and uninsured patients who meet guidelines for screening or diagnostic colonoscopies are referred to a local medical provider for this procedure. Under contract with Fort Bend County Clinical Health Services, the local medical provider (negotiations underway) would provide the following:
- Instructions on preparation for the procedure, including prescriptions if needed
- Appointment scheduling for the procedure
- Coverage of the anesthesia, colonoscopy procedure and pathology, if required
- Acceptance for cancer surgery, radiation and/or chemotherapy for a patient diagnosed with colon/rectal cancer at a contracted rate.

The population of uninsured and underinsured individuals in Fort Bend County does not currently have access to low cost or no cost colonoscopies. The Federally Qualified Health Center (AccessHealth) can only provide Fecal Occult Blood (FOBT) testing and has no referral source for colonoscopies for those without insurance coverage or without means to pay. The County Indigent Health Care Program can only provide payment for services to those who are below 21% of the federal poverty level and who already have a health condition such as a positive FOBT or other medical indication of need. Preventive screening is not covered.

The project will include education to the target population through AccessHealth and other points of contact with this population about colorectal cancer, the importance and benefits of screening and the availability of the new project to make this available.

Target Zip codes for the program are:

<table>
<thead>
<tr>
<th>Zip codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>77053</td>
</tr>
<tr>
<td>77406</td>
</tr>
<tr>
<td>77407</td>
</tr>
<tr>
<td>77417</td>
</tr>
<tr>
<td>77441</td>
</tr>
<tr>
<td>77444</td>
</tr>
<tr>
<td>77451</td>
</tr>
<tr>
<td>77459</td>
</tr>
<tr>
<td>77461</td>
</tr>
<tr>
<td>77464</td>
</tr>
<tr>
<td>77469</td>
</tr>
<tr>
<td>77471</td>
</tr>
<tr>
<td>77476</td>
</tr>
<tr>
<td>77477</td>
</tr>
<tr>
<td>77478</td>
</tr>
<tr>
<td>77479</td>
</tr>
<tr>
<td>77481</td>
</tr>
<tr>
<td>77487</td>
</tr>
<tr>
<td>77489</td>
</tr>
<tr>
<td>77494</td>
</tr>
<tr>
<td>77496</td>
</tr>
<tr>
<td>77497</td>
</tr>
<tr>
<td>77498</td>
</tr>
<tr>
<td>77545</td>
</tr>
</tbody>
</table>

Goals and Relationship to Regional Goals:
The goal of this project is to provide evidence-based prevention for colon and rectal cancers in the uninsured and underinsured population of Fort Bend County. The expected outcomes include:
- Prevention of colorectal cancers by the removal of precancerous polyps
- Reduction in cost and increase in cures by early detection of colorectal cancer.

The project meets the following regional goal:
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
**Challenges:**

The populations targeted by this program currently have no available low cost or no cost option for screening or diagnostic colonoscopies. One challenge will be the education of the population that this service is now available to them and why it is important. A second major challenge will be if the percentage of the patients who are screened and are diagnosed with cancer is higher than anticipated. This will place a higher burden on the contracted entity than planned based on current population estimates of colorectal cancers.

**5-year Expected Outcome for Provider and Patients:**

Fort Bend County expects to see increases in the number of uninsured and underinsured who are able to take advantage of the screening recommendations for colorectal cancer. In addition, any patient whose screening results in a need for further medical treatment will be able to complete the needed treatment under contractual agreement between the performing provider and a local medical provider.

**Starting Point/Baseline:**

Baseline data is limited to the Texas Department of State Health Services surveillance for colorectal cancer morbidity and mortality, as noted below. During the planning stage of the program, local data from health care providers will be gathered to enhance the state provided data. In the first six months of the program, data gathering systems will be put in place to monitor the successful referral, engagement and outcomes for the patients who are referred in, using a rapid cycle improvement method.

**Rationale:**

**Reasons for selecting the project option:**

Fort Bend County does not have a hospital district structure for indigent healthcare or for the uninsured and underinsured population of the County. The County participates in the state mandated Indigent Health Care Program which provides care for qualifying individuals whose income is below 22% of the Federal Poverty Level. With a population estimate of 606,000, there are more than 48,500 (8%) individuals living below the Federal Poverty Level and up to 115,140 uninsured at this time in the County. For these individuals, medical care is often beyond their economic reach. Cash payment options and even sliding scale fees take lower priority than housing payments and food. Expensive screening and diagnostic colonoscopies are beyond the reach of the majority of these individuals.

Data shows that the current incidence rate for Colon and Rectal cancer in Fort Bend County is 38.6 per 100,000 population, and the death rate is 15.5 per 100,000. Even without assuming that the incidence and death rate is higher in the uninsured and underinsured (therefore unscreened) population, these rates would result in 44 cases of colorectal cancer and 18 deaths due to this cancer in the uninsured population of Fort Bend County.

**Project Components:**

Project Option: 2.7.1 does not have required components.

**Milestones and Metrics:**

Process Milestones and Metrics
P-1. Milestone: Development of innovative evidence-based project for targeted population.
Metric P1.1: Document Innovational Strategy and Plan
   a. Data Source: Documentation of meetings and discussion leading to contract for colonoscopy services.
   b. Rationale/Evidence: Meeting minutes, preliminary program designs, contract for services

Metric P2.1: Document implementation strategy and testing outcomes
   a. Data Source: Program protocols and procedures, Numbers of colonoscopies performed and outcomes
   b. Rationale/Evidence: To identify, develop and test new models of healthcare delivery and disease management lays the groundwork for widespread adoption of innovative care that can lead to a system that delivers better health, better care at reduced costs.

P-7. Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. (Metric P-8.1)

The project will include a continuous quality improvement component. Rapid cycle improvement will be used to test the program as it is implemented and adjust the components to reach the broadest possible target population which especially includes the safety net population in the county.

Improvement Milestones and Metrics
I-X. Milestone: Increase awareness of the risk of colorectal cancer and the disease prevention afforded by colonoscopy screening in target population.
Metric 1.X.1: Increase percentage of the target population reached
   a. Numerator: Number of individuals of target population reached with educational programs.
   b. Denominator: Number of individuals in the target population
   c. Data Source: documentation of outreach, education and referrals in the target population
   d. Rationale/Evidence: Low Socioeconomic status (income, unemployment, educational level and residence) has been associated with lower screening participation in many studies. Response efficacy, the perception that a recommended response will prevent the threat from happening, and self-efficacy, perception of the individual’s ability to perform a recommended response are key elements to uptake of recommended behaviors that can be addressed in effective education. In addition, an improvement in the referral of patients for screening delivery capacity improvements and navigation assistance have been shown to increase screening uptake.

Unique community need identification number the project addresses:
- CN.1 Inadequate access to primary care
- CN.2 Inadequate access to specialty care
How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
This project is based in the evidence of cancer prevention and successful treatment resulting from appropriate and early screening for colorectal cancers, which is currently not available to the uninsured and underinsured population in our County. At this time, there is no referral available for screening and very limited availability of treatment resource or payment options for diagnosed colorectal cancer.

Related Category 3 Outcome Measures:
OD-6 Patient Satisfaction (IT-6.1 – Patient Access to Specialist, Shared Decision Making)
OD-12 Primary Care and Primary Prevention (IT-12.3 – Colorectal Cancer Screening)

Reasons/Rationale for selecting the outcome measures:
The target population has limited access to specialist care and valuable data can be gathered from the survey regarding their satisfaction with and experience with the specialist and also as to whether they feel a part of the process in deciding what will happen in their health care plan as they access resources not previously available to them. The measurement of the numbers of colonoscopies performed per targeted population will measure the success of the project in reaching and engaging the target population in prevention of a serious health issue.

Relationship to other Projects:
This project supports and enhances the Expand a Patient Navigation system project that is proposed in the Fort Bend County pass one project. The medical home and patient navigation system will now have a resource to refer patients to for primary prevention and treatment of a curable cancer.

Relationship to Other Performing Providers’ Projects in the RHP:
The increase of primary care and specialty care will naturally result in additional ambulatory care encounters for our region patient base. The ambulatory initiatives cover items such as laboratory, PT/OT, social work, etc. and are a necessity of our patients to ensure a comprehensive treatment for access as well as cost avoidance. The Region 3 initiative grid in the addendum reflects all ambulatory operations initiatives.

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

Project Valuation:
Valuation is based on cost avoidance, projecting savings associated with prevention of a life threatening disease and potentially detecting the cancer early enough from rapid and successful treatment. At an average annual cost of $3,000 for co-morbidity treatment. The cost savings of early detection and treatment over five years is estimated at $600,000.
References:
2. http://www.dshs.state.tx.us/tcr
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 1 [P-1]: Development of an innovative evidence-based project for targeted population</td>
<td>Milestone 2 [P-2]: Implement evidence-based innovational project for targeted population</td>
<td>Milestone 3 [P-7]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects</td>
<td>Milestone 4 [P-7]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects</td>
</tr>
</tbody>
</table>
| Metric 1 [P-1.1]: Document Innovational Strategy and Plan:  
- Description of target population  
  - Level of colonoscopy adoption  
  - Gatekeepers  
  - Education providers  
- Best practices research  
  - Program models.  
- Data Source: Documentation of meetings, research and discussions leading to development of a contract for colonoscopy services and an outreach program | Metric 1 [P-2.1]: Document implementation strategy and testing outcomes  
  - Goal: Refer 50 patients for colonoscopy screening:  
    - Data Source: Documentation of education, outreach and referrals. Appointment and outcome reports | Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.  
  - Goal: Participate in all RHP organized meetings/seminars  
  - Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes | Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.  
  - Goal: Participate in all RHP organized meetings/seminars  
  - Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes |
| Milestone 1 Estimated Incentive Payment: $105,475 | Milestone 2 Estimated Incentive Payment: $59,187 | Milestone 3 Estimated Incentive Payment: $65,049 | Milestone 4 Estimated Incentive Payment: $41,110 |
| Milestone 5 [P-7] Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects | Milestone 6 [P-7] Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects | | Milestone 7: [P-7] Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects |
| Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.  
  - Goal: Participate in all RHP organized meetings/seminars  
  - Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes | Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.  
  - Goal: Participate in all RHP organized meetings/seminars  
  - Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes | | Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.  
  - Goal: Participate in all RHP organized meetings/seminars  
  - Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes |
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 3</td>
<td>Outcome Measure(s):</td>
<td>Patient Satisfaction – Access to Specialist/Shared Decision Making</td>
<td>Milestone 7 Estimated incentive Payment $41,109</td>
</tr>
<tr>
<td>2967606-01 3.8</td>
<td>2967606-01 3.9</td>
<td>Primary Care and Primary Prevention – Colorectal Cancer Screening</td>
<td>Milestone 8 Estimated incentive Payment $41,109</td>
</tr>
<tr>
<td>N/A</td>
<td>IT-6.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMPLEMENT EVIDENCE-BASED DISEASE PREVENTION PROGRAMS</td>
<td>(Colonoscopy Screening Program)</td>
<td>Milestone 8 [I-X]: Increased awareness of the risk of colorectal cancer and the disease prevention afforded by colonoscopy screening in target population.</td>
<td>Milestone 8 Estimated incentive Payment $41,109</td>
</tr>
<tr>
<td>Fort Bend County</td>
<td></td>
<td>Metric 1 [I-X.1]: Increased percentage of the target population reached.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Baseline: TBD in Year 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Goal: 100% increase in number of target population reached with outreach awareness program.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data Source: Program schedules, attendance rosters, pre- and post-test.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Milestone 3 Estimated incentive Payment $59,187</td>
<td>Milestone 5 Estimated incentive Payment $64,050</td>
<td>Milestone 8 Estimated incentive Payment $41,109</td>
</tr>
<tr>
<td></td>
<td>Year 2 Estimated Milestone Bundle Amount: $105,475</td>
<td>Year 3 Estimated Milestone Bundle Amount: $118,374</td>
<td>Year 4 Estimated Milestone Bundle Amount: $128,099</td>
</tr>
<tr>
<td></td>
<td>Year 4 Estimated Milestone Bundle Amount: $123,328</td>
<td>Year 5 Estimated Milestone Bundle Amount: $123,328</td>
<td>Year 5 Estimated Milestone Bundle Amount: $123,328</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5): $475,276*
Gulf Bend
Pass 2
Project Option 2.15.1-Integrate Primary and Behavioral Health Care Services: Person-Centered Behavioral Health Medical Home

**Unique RHP Project Identification Number:** 1352544-07.2.1/Pass 2

**Performing Provider Name/TPI:** Gulf Bend Center / 1352544-07

Pass 1 Category 2 Project

- **Provider:** Gulf Bend Center is the Community Mental Health Center located in Victoria, Texas. Gulf Bend Center provides services to individuals in the following seven county area: DeWitt, Lavaca, Jackson, Goliad, Victoria, Calhoun, and Refugio. Gulf Bend Center’s Local Service Area has a population of approximately 200,000. Today, Gulf Bend Center is funded to serve an average 608 unduplicated adults per year. The Center currently reaches 1,800 adults a year with the help of local contributions, foundation grants and other forms of resource leveraging.

- **Intervention:** Develop and implement a Person-Centered Behavioral Health Medical Home in Port Lavaca, TX. The center will target at risk populations with co-morbid diseases of mental illness and chronic disease who currently go untreated or under treated and who routinely access more intensive and costly services such as emergency departments or jails. The person-centered behavioral health medical home will offer the following services in the same location:
  - Behavioral Health Services
  - Primary care services
  - Health behavior education and training programs
  - Long and short term care for those with mental illness and co-occurring chronic disease
  - Case Management services to help patient navigate the services provided in the community

- **Need for project:** The need for this project was based upon data for Victoria County from the Texas Department of State Health Services for preventable hospitalizations from diabetes, asthma, and COPD with a coexisting behavioral/mental health disorder. The data showed the following:
  - Between 2005 and 2010, there were 48 hospitalizations for diabetes complications that totaled $2,170,723 in charges. Using national statistics above, we can conclude that of those 48 hospitalizations, that 15 had a co-occurring mental illness. If those 15 patients had access to integrated care, it would have lead to a cost savings of $678,345.
  - Further data from Memorial Medical Center shows that 231 individuals were seen in the Emergency Department in 2011 with a primary behavioral health diagnosis. Using national statistics, of those 231 individuals, 157 had a co-occurring chronic disease.

- **Target population:** The target population are the at risk populations with co-morbid diseases of mental illness and chronic disease

---

1 Per DSHS, the average hospital charge for a diabetes admission in Calhoun County from 2005 to 2010 was $45,223
• **Category 1 expected benefits:** The project seeks to decrease inpatient and ED admissions for co-occurring mental illness and chronic diseases, lower the costs of providing care, and providing greater access to primary care for those with co-occurring mental illness and chronic diseases. Gulf Bend will serve 100 patients in DY 2, 125 patients in DY 3, 150 patients in DY 4, and 200 patients in DY 5.

• **Category 3 outcomes:** The Category 3 Outcome Measure chosen by Gulf Bend for this project is OD-2 Potentially Preventable Admissions - IT-2.4 Behavioral Health/Substance Abuse Admission Rate
  - One for BH/SA as the principal diagnosis
  - A secondary category in which a significant BH/SA secondary diagnosis is present (i.e. reduction in admission rate with a primary diagnosis of diabetes/COPD with a secondary diagnosis of mood/affective disorders.)

Gulf Bend will attempt to decrease admissions due to diabetes and COPD with an underlying or co-existing mental health disorder by 25% by the end of DY 5.
Project Option2.15.1-Integrate Primary and Behavioral Health Care Services: Person-Centered Behavioral Health Medical Home

Unique RHP Project Identification Number: 1352544-07.2.1/Pass 2
Performing Provider Name/TPI: Gulf Bend Center / 1352544-07

Project Description:
This project will integrate behavioral health and primary care services in a clinic operated by Gulf Bend Center in Calhoun County, Texas where access to these services is limited by geographical and socioeconomic barriers.

The goal of this project is to develop and implement a Person-Centered Behavioral Health Medical Home, targeting at risk populations with co-morbid diseases of mental illness and chronic disease who currently go untreated or under treated and who routinely access more intensive and costly services, such as emergency departments or jails. This project proposes a solution by offering a site that will integrate primary care into the behavioral health services that Gulf Bend already provides in its service region, which includes the counties of DeWitt, Lavaca, Jackson, Goliad, Victoria, Calhoun, and Refugio. The person-centered behavioral health medical home will offer the following services in the same location:

1. Behavioral Health Services
2. Primary care services
3. Health behavior education and training programs
4. Long and short term care for those with mental illness and co-occurring chronic disease
5. Case Management services to help patient navigate the services provided in the community.

Clients will receive proactive, ongoing behavioral health services that keep them healthy and empower them to self-manage their conditions in order to avoid their health worsening and needing ED or inpatient care. In DY 2, Gulf Bend estimates that it will serve 100 individuals with Medicaid as their primary insurance and suffering from co-occurring chronic disease and mental/behavioral illness. In DY 3, Gulf Bend will increase the number of patients served to 125 and then increase to 150 by then end of DY 4. At the end of DY 5, Gulf Bend will be offering integrated primary care and behavioral health services to 200 clients through this project.

Goals and Relationship to Regional Goals:
The goals for this project include:
- Increase in access to primary care
- Increase in access to behavioral health care services
- Reduction in inpatient psychiatric hospitalizations
- Implement the IMPACT model of integrated collaborative care
- Increase in patient satisfaction
- Reduction in Emergency Department visits
- Chance to develop and change health behaviors
- Reduction in preventable behavioral health and chronic disease hospitalizations

This project meets the following regional goal(s):
Improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

**Challenges:**
Gulf Bend will face several challenges in opening and operating a satellite behavioral health clinic in Calhoun County. The first challenge will be determining the best location within Calhoun County to provide these services. To meet this challenge, Gulf Bend will engage city and community official and stakeholder input as to the best location for the new clinic. The second challenge will be determining the correct staff and staffing ratio to be efficient in delivering behavioral health services at the satellite clinic. Gulf Bend feels that this challenge can be overcome by researching and engaging other community health centers for a solution to this challenge. The third, and final, challenge will be operating a clinic that will be located 45 minutes away. Gulf Bend will meet this challenge by hiring a clinic manager, who will be responsible for the day to day operations of the clinic.

**5-Year Expected Outcome for Provider and Patients:**
The five year expected outcome through the development and implementation of the Person-Centered Behavioral Health Medical Home project is to provide critical services to the targeted population with co-morbid diseases of mental illness and chronic disease that currently go untreated or under treated. Through the delivery of integrated medical and behavioral health care we expect to see individuals with a treatment plan developed and implemented with delivery provided by those with primary care and behavioral health expertise. We also expect to see an overall reduction in costs and an increase in the overall satisfaction and health and well-being of this population.

**Starting Point/Baseline:**
Gulf Bend Center currently provides behavioral health services for primarily indigent or Medicaid-eligible clients who have schizophrenia, bipolar disorder, and major depression in its seven county service area. Gulf Bend Center’s Local Service Area has a population of approximately 200,000. Of the 200,000, roughly 12,000 have Medicaid as their primary insurance. Currently, 10% of Gulf Bend clients reside in Calhoun County. Of the 97 clients, 78 are adult and the remaining 19 are children/adolescents Using national statistics we can conclude approximately 50,000 individuals have some form of mental illness of which 34,000 likely have a medical and/or chronic disease. Today, Gulf Bend Center is funded to serve an average 608 unduplicated adults per year. The Center currently reaches 1,800 adults a year with the help of local contributions, foundation grants and other forms of resource leveraging. Gulf Bend will not be using alternate Federal funds for this project. Gulf Bend will be using General Revenue and Mediicaid revenue from its performed services to help with this project.

**Rationale:**
Gulf Bend selected this project because of the critical need for these services, which was based upon national and local data. Co-occurring mental and physical health issues are common in the general population but are significant for persons with serious mental illness. National statistics demonstrate on average more than 68% of adults with a mental disorder had at least one medical condition, and 29% of those with a medical disorder also had a mental health condition. People
with schizophrenia and bipolar disorder are up to three times more likely to have three or more chronic conditions compared to people without these disorders. Research has shown that those patients affected by mental illness and suffering from chronic disease are dying 25 years earlier than the rest of the population\(^1\).

There is a demonstrated community need in Calhoun County for this project. Texas Department of State Health Services data showed alarming rates of chronic disease and preventable hospitalizations based upon data from 2005 to 2010. Between 2005 and 2010, there were 48 hospitalizations for diabetes complications that totaled $2,170,723 in charges. Using national statistics above, we can conclude that of those 48 hospitalizations, that 15 had a co-occurring mental illness. If those 15 patients had access to integrated care, it would have lead to a cost savings of $678,345\(^2\). Further data from Memorial Medical Center shows that 231 individuals were seen in the Emergency Department in 2011 with a primary behavioral health diagnosis. Using national statistics, of those 231 individuals, 157 had a co-occurring chronic disease. Research has shown that patient centered medical homes that use the IMPACT model of collaborative care have lead to improved outcomes in physical health, benefited various populations and have provided a lower cost of long term health care services\(^3\). Druss and colleagues conducted a randomized trial of patients within the Veterans Administration system in 2001. In the study, individuals living with serious mental illnesses were to receive primary care in an integrated behavioral health-primary care patient focused model of care. The study showed that individuals were significantly more likely to have made a primary care visit, had a greater mean number of primary care visits, were more likely to have received 15 of 17 preventive measures, and had a significantly greater improvement in their health\(^4\). Research has shown that the integration of primary care and behavioral health services in the same service location has increased outcomes for those suffering from mental illness and co-occurring chronic disease. A reason for these improved outcomes is due to the fact that integrated care offers "one-stop shopping"\(^5\) for its patients. Data from the Bureau of Primary Care shows that only 1 in 4 patients referred for mental health or chronic disease management make the first appointment. The same research further showed that co-location of integrated primary care services and behavioral health services resulted in improved behavioral health and chronic disease outcomes and proved to provide cost savings.

Several studies have shown the effectiveness of integrated patient centered homes for those suffering from co-occurring co-morbid diseases. On study performed in Texas showed that using an integrated collaborative care site using the IMPACT model of care enhanced access to mental health services, improved quality of life, reduced the occurrence of depression and anxiety, decrease in the utilization of unnecessary emergency department services, and a reduction in overall health care costs\(^6\). In the study, researchers found that anxiety scores fell by 50%, emergency department use decreased by 50%, and the average health care cost per enrolled

---

1. Freeman, E, Yoe, J. The Poor health status of consumers of mental healthcare: Behavioral disorders and chronic disease, Presentation to NASMHPD Medical Directors Work Group, May 2006.
2. Per DSHS, the average hospital charge for a diabetes admission in Calhoun County from 2005 to 2010 was $45,223
decreased by 17% in the second year and 56% in the third year of the program. This data is significant because the targeted patient population size is similar in the Gulf Bend area.

There is another benefit to an integrated collaborative care site. The other benefit of an integrated approach that will help reduce the number of admissions is long-term compliance. In 2000, researchers found that patients that receive care in an integrated care site show a higher level of adherence and retention in treatment. This translates into an overall decrease in hospital admissions. This is because the patient only has to travel to one location for their behavioral and physical health services and has increased access to those services.

The research and data shown above provides evidence that Gulf Bends Category 2 project will have a significant impact and help achieve its selected Category 3 outcome measure. Gulf Bend will be integrating primary care into its existing behavioral health services and will therefore be able to reduce admissions of those affected with co-occurring co-morbid disease.

**Project Components:** We propose to meet all of the required core project components as follows:

a) Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community. This will be accomplished through community stakeholder meetings. A site will be chosen that will increase access to the integrated services based upon community need and resources, as well as the needed space requirements. Gulf Bend will secure a long term lease to meet this goal.

b) Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated through stakeholder meetings on a weekly or monthly basis.

c) Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers based upon evidence based best practice models, such as the IMPACT model of collaborative care.

d) Recruit a number of specialty providers (physical health, mental health, substance abuse, etc) to provide services in the specified locations based upon community and clinic needs, as well as analysis of unduplicated patient visits. Gulf Bend will use provider recruiting and staffing agencies, postings on national association websites, and journals to recruit the needed providers.

e) Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include:
   - Regular consultative meetings between physical health and behavioral health practitioners;
   - Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners; and/or
   - Shared treatment plans co-developed by both physical health and behavioral health practitioners.

   This will be accomplished by holding weekly or semi-weekly meetings between providers and support staff to make sure that collaborative care is used.

f) Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated electronic health record system or participation in a health information exchange – depending on the size and scope of the local project. Gulf Bend will pursue the implementation of an EHR that will allow ease of use when sharing a patient’s health information and medical records among providers.
g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice through the advice and use of Gulf Bend's legal counsel.

h) Arrange for utilities and building services for these settings by calling the utility company within Port Lavaca.

i) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings. The collection methods and reporting mechanisms will be based upon a best practice model from an organization that has already implemented integrated health care.

j) Conduct quality improvement for project using methods such as rapid cycle improvement. Gulf Bend currently has a Quality Improvement board made up of several members of the executive management team and quality management staff. The QI board will develop and implement quality practices for the integrated care based upon evidence based best practice methods.

Unique community need identification numbers the project addresses:
The primary care/behavioral health integration proposed in this plan relates to community needs CN.1, CN.3, CN.5, CN.6, CN.7, CN.8, CN.9, CN.10, CN.11, CN.18, CN.20, CN.23.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: In Gulf Bend's service region, integrated care sites do not exist. This integrated medical home presents a new, more efficient, project that will begin to treat the person as a whole. The behavioral health and primary care system in the region currently operate in silos with lack of care coordination and communication among behavioral health and primary care providers. This results in less than favorable health outcomes for those with co-occurring chronic disease and mental illness. The integrated care site operated by Gulf Bend will be the first of its kind and will have a positive impact upon the residents of Calhoun County.

Related Category 3 Outcome Measure(s): OD-2 Potentially Preventable Admissions - IT-2.4 Behavioral Health/Substance Abuse Admission Rate
  1. One for BH/SA as the principal diagnosis
  2. A secondary category in which a significant BH/SA secondary diagnosis is present (i.e. reduction in admission rate with a primary diagnosis of asthma/diabetes/COPD with a secondary diagnosis of mood/affective disorders.)
Gulf Bend will attempt to decrease admissions due to diabetes and COPD with an underlying or co-existing mental health disorder by 25% by the end of DY 5.

Reason/rationale for selecting the outcome measure: Using the above statistics from national, state, and local data sources, there is a community need to prevent admissions in hospitals in Calhoun County for co-occurring co-morbid diseases. The integrated delivery of care will help prevent these admissions and help reduce the overall cost of providing health care to these patients.

Relationship to Other Projects: This project is related to all initiatives designed to support Primary and Behavioral Health Services redesign for improved patient satisfaction and access to care. Its focus and emphasis on improving patient experience, outcomes, coordination of care
and access to specialty services will enhance and support many projects within the region, particularly those projects designed to improve access to care and reduce inappropriate ED utilization, including the following: 020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas; 1352544-07.1.1 (RHP 4 project) – Development of behavioral health crisis stabilization services as alternatives to hospitalization; 121775403.1.6 – Development of a crisis stabilization/urgent care center to provide screening and assessments to determine the appropriate level of care, and 121990904.2.1 – Integrate primary and behavioral health care services. Related category 4 measures include potentially preventable admissions measures in RD-1.3, and Patient Satisfaction in RD-4.1, and Potentially Preventable Readmissions in RD-2.

**Relationship to Other Performing Providers' Projects in the RHP:** This project will provide coordination of efforts with LMHAs that will result in great learning opportunities. Through the learning collaborative, we will work with other community entities to discuss challenges, lessons learned and obstacles to delivery. The collaborative will provide an ideal learning opportunity and sharing of ideas. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System.

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

**Project Valuation:**
Gulf Bend considered several factors in valuing this project including reductions in costs associated with emergency room visits and hospitalizations for diseases and illnesses. Improving the physical health of behavioral health clients should reduce the number of ED visits and the occurrences of hospitalizations. The average cost of an ED visit in Gulf Bend's area is $1,265; average cost of a diabetes-related hospital stay is about $45,000 with a COPD related stay averaging $31,500 in Calhoun County. If Gulf Bend were to prevent hospitalizations due to COPD and Diabetes in Calhoun County, it could lead to a cost savings of over $3 million dollars. The decrease in costs due to a decrease in hospital admissions is not the only costs determining factor used in this valuation. One valuation was the affect on the patient themselves. Due to these services, Gulf Bend feels that healthier individuals will have a longer and more productive life span. Those persons with mental illness and co-occurring chronic disease have a lifespan of 25 years less than those who do not have a co-occurring mental illness. Since patients will receive the needed primary care services and studies have shown that compliance is increased, Gulf Bend expects these patients to be able to be more productive and help contribute to the overall benefit of society. Studies have shown that depression is the leading cause of a decrease in productivity in the work place. If the integration of services were to help increase the

---

6 Texas Preventable Hospitalization data from 2005 to 2010.
productivity of patients suffering from a mood disorder and co-occurring chronic disease then the community will benefit as a whole.
### Integrate Primary and Behavioral Health Care Services

**Gulf Bend Center**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>096166602.3.1</th>
<th>OD-6 IT-6.1 (1)</th>
<th>Percent improvement over baseline of patient satisfaction scores—Patients are getting timely care, appointments, and information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 1 [P-2]: Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new settings or for physicians to share their office space with behavioral health practitioners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-2.1]: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: 0/5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Information from persons interviewed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $237,500</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-4]: Assess ease of access to potential locations for project implementation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3</strong> [P-4.1]: Needed employees hired by start date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: 0/3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Employee roster</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 5 Estimated Incentive Payment: $180,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5</strong> [P-3]: Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-3.1]: Number and types of referrals that are made between providers at the location</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: 0/20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Sources</strong>: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment: $180,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 6</strong> [P-X2]: Recruit and hire needed primary and behavioral health staff based upon needs assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-X2.1]: Needed employees hired by start date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: 0/3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Employee roster</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 5 Estimated Incentive Payment: $180,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 7</strong> [P-7]: Evaluate and continuously improve integration of primary and behavioral health services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (e.g. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: 0/2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 8 Estimated Incentive Payment (maximum amount): $300,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 10</strong> [P-7]: Evaluate and continuously improve integration of primary and behavioral health services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (e.g. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: 0/2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 8 Estimated Incentive Payment (maximum amount): $300,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 11</strong> [I-9]: Coordination of Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [I-9.1]: 150 individuals with a treatment plan developed and implemented with primary care and behavioral health expertise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: 125/150</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Project Data; Medical Records; Claims and Encounter Data</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 11 Estimated Incentive Payment: $160,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 12</strong> [I-10]: Improved consumer satisfaction with integrated services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [I-10.1]: 45% of People report satisfaction with integrated services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal</strong>: 45% improvement above baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Completed consumer satisfaction surveys</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 12 Estimated Incentive Payment: $180,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 13</strong> [I-11]: Health Metrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [I-11.1]: 20% Increase in positive results of standardized health metrics which may include objective health indicators such as body mass index, glycated hemoglobin (A1c), blood pressure; behavioral health instruments such as Quality of Life (QOL) Questionnaire, Adult Needs and Strengths Assessment (ANSA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal</strong>: 20% increase from baseline in positive results of standardized health metrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Project Data; Medical Records; Claims and Encounter Data</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 13 Estimated Incentive Payment: $160,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 14</strong> [I-12]: Improved consumer satisfaction with integrated services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [I-12.1]: 45% of People report satisfaction with integrated services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal</strong>: 45% improvement above baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Completed consumer satisfaction surveys</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 14 Estimated Incentive Payment: $180,000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Regional Healthcare Partnership Plan**

Region 3
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Integrate Primary and Behavioral Health Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>OD-6 IT-6.1 (1)</td>
<td>Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1</strong> [P-4.1]: Access to major roadways, bus routes, or proximity to a large number of individuals who may benefit from services. Baseline/Goal: 0</td>
<td>Payment:$ 180,000</td>
<td>Data Source: Project data; claims and encounter data; medical records</td>
<td>Milestone 12 Estimated Incentive Payment: $160,000</td>
</tr>
<tr>
<td><strong>Data Source</strong>: City/County data, maps, demographic data relating to prevalence of health conditions</td>
<td>Milestone 7 [P-5]: Develop integrated sites reflected in the number of locations and providers participating in the integration project:</td>
<td>Milestone 9 Estimated Incentive Payment: $300,000</td>
<td><strong>Metric 1</strong> [I-10]: No-Show Appointments</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> Estimated Incentive Payment: $237,500</td>
<td><strong>Metric 1</strong> [P-5.2]: Number of primary care providers newly located in behavioral health settings. Baseline/Goal: 0/1</td>
<td><strong>Data Source</strong>: Project data</td>
<td>Milestone 15 [I-8]: Integrated Services</td>
</tr>
<tr>
<td><strong>Milestone 3</strong> [P-X1] Develop and create policies, procedures, and treatment plans for the delivery of integrated care</td>
<td><strong>Data Source</strong>: Project data</td>
<td>Milestone 6 Estimated Incentive Payment: $180,000</td>
<td><strong>Metric 1</strong> [I-8.1]: 25% of Individuals receiving both physical and behavioral health care at the established locations</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Gulf Bend Policy and Procedure Manual</td>
<td>Milestone 8 [P-6]: Develop integrated behavioral health and primary care services within co-located sites.</td>
<td><strong>Baseline/Goal</strong>: 0/1</td>
<td><strong>Goal</strong>: 25% improvement above baseline</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-X1.1]: Policy and procedure manual Baseline/Goal: 0</td>
<td><strong>Data Source</strong>: Project data</td>
<td><strong>Data Source</strong>: Project Data; Clinic Registry Data; Claims and Encounter Data</td>
<td><strong>Data Source</strong>: Project data; claims and encounter data; medical records</td>
</tr>
<tr>
<td><strong>Milestone 3 Estimated Incentive Payment: $237,500</strong></td>
<td>Milestone 7 Estimated Incentive Payment:$ 180,000</td>
<td>Milestone 10 Estimated Incentive Payment: $300,000</td>
<td>Milestone 12 Estimated Incentive Payment: $160,000</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-6.1]: Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system). Baseline/Goal: 0/1</td>
<td><strong>Data Source</strong>: Project data</td>
<td><strong>Milestone 7 Estimated Incentive Payment :$ 180,000</strong></td>
<td>Milestone 15 [I-9]: Coordination of Care</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [I-10.1]: 10% decrease the “no shows” for behavioral and physical health appointments</td>
<td><strong>Data Source</strong>: Project Data; Clinic Registry Data; Claims and Encounter Data</td>
<td>Milestone 8 Estimated Incentive Payment: $300,000</td>
<td><strong>Metric 1</strong> [I-9.1]: 200 individuals with a treatment plan developed and implemented with primary care and behavioral health expertise</td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: 150/200</td>
<td><strong>Data Source</strong>: Project data; claims and encounter data; medical records</td>
<td><strong>Milestone 14 Estimated Incentive Payment: $160,000</strong></td>
<td><strong>Baseline/Goal</strong>: 150/200</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Project data; claims and encounter data; medical records</td>
<td>Milestone 13 Estimated Incentive Payment: $160,000</td>
<td>Milestone 16 [I-9]: Coordination of Care</td>
<td><strong>Data Source</strong>: Project data; claims and encounter data; medical records</td>
</tr>
</tbody>
</table>

**Milestone 12** Estimated Incentive Payment: $160,000

**Milestone 15** [I-8]: Integrated Services

**Milestone 16** [I-9]: Coordination of Care

**Metric 1** [I-9.1]: 200 individuals with a treatment plan developed and implemented with primary care and behavioral health expertise
### Integrate Primary and Behavioral Health Care Services

**Gulf Bend Center**

#### Related Category 3 Outcome Measure(s):%

- **096166602.3.1**
- **OD-6 IT-6.1 (1)**

#### Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 4 [I-9.]: Coordination of Care</strong></td>
<td><strong>Milestone 9 [I-9]: Coordination of Care</strong></td>
<td><strong>Milestone 9 [I-9.1]: 125 individuals with a treatment plan developed and implemented with primary care and behavioral health expertise</strong></td>
<td><strong>Milestone 15 [I-10]: No-Show Appointments</strong></td>
</tr>
<tr>
<td><strong>Metric 1 [I-9.1]: 100 individuals with a treatment plan developed and implemented with primary care and behavioral health expertise</strong></td>
<td><strong>Metric 1 [I-9.1]: 125 individuals with a treatment plan developed and implemented with primary care and behavioral health expertise</strong></td>
<td><strong>Metric 1 [I-10.1]: 20% decrease the “no shows” for behavioral and physical health appointments</strong></td>
<td></td>
</tr>
<tr>
<td>Data Source: Project data; claims and encounter data; medical records</td>
<td>Data Source: Project data; claims and encounter data; medical records</td>
<td>Data Source: Project Data; Clinic Registry Data; Claims and Encounter Data</td>
<td></td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment: $237,500</td>
<td>Milestone 9 Estimated Incentive Payment: $180,000</td>
<td>Milestone 9 Estimated Incentive Payment: $180,000</td>
<td>Milestone 15 Estimated Incentive Payment: $160,000</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone): $950,000

**Year 3 Estimated Milestone Bundle Amount:** $900,000

**Year 4 Estimated Milestone Bundle Amount:** $900,000

**Year 5 Estimated Milestone Bundle Amount:** $800,000

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5): $3,550,000*
Harris County Hospital District Ben Taub General Hospital
Pass 1
**Project Option 2.5.4- “Other” project option: Implement other evidence-based project that will impact cost efficiency in an innovative manner: Ambulatory Care Central Fill Pharmacy**

**Unique RHP Project ID:** 133355104.2.1 / Pass 1  
**Performing Provider Name/TPI:** Harris Health / 133355104

**Project Summary:**

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

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

**Intervention(s):**
This project will create an automated ambulatory central fill pharmacy to facilitate dispensing up to 10,000 prescriptions per shift with a 24 hour turnaround time and mail order capability.

**Need for the project:**
Currently, Harris Health System has no automated prescription counting technology. Annually, 2.5M prescriptions are counted manually, using only a counting tray and spatula. A Central Fill facility will provide efficiencies in conjunction with the existing ePrescribing system to improve the patient’s pharmaceutical experience by improving safety, wait times, turnaround times, access, and convenience.

**Target Population:**
All patients with prescription medications within the system with may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

**Category 1 or 2 expected patient benefits:**
Our goal is to increase to 50% of total monthly prescription volume from established baseline of 0% prescriptions filled at central fill facility (based on 2.5M annual prescription volume) in DY4 and increase to 60% (1.5M annual) in DY5.

**Category 3 outcomes:**
IT-5.1: Our goal is to decrease the average labor cost per prescription 7% from established baseline in DY3 (based on 2.5M annual prescription volume), 19% in DY4, and 31% in DY5.
Project Option 2.5.4- “Other” project option: Implement other evidence-based project that will impact cost efficiency in an innovative manner: Ambulatory Care Central Fill Pharmacy

Unique RHP Project ID: 133355104.2.1 / Pass 1
Performing Provider Name/TPI: Harris Health / 133355104

Project Description:
Harris Health proposes to create an automated ambulatory central fill pharmacy to facilitate dispensing up to 10,000 prescriptions per shift with a 24 hour turnaround time and mail order capability.

Currently, Harris Health System has no automated prescription counting technology. Annually, 2.5M prescriptions are counted manually, using only a counting tray and spatula. Central Fill automation will include robotics which will count and dispense the pills into a prescription container, label and cap the prescription container, and sort and package the prescriptions for delivery to the patient or local pharmacy. A Central Fill facility will provide efficiencies in conjunction with the existing ePrescribing system to improve the patient’s pharmaceutical experience by improving safety, wait times, turnaround times, access, and convenience. Central Fill automation will provide 99.99% prescription dispensing accuracy for improved medication safety. Prescription mail order will provide increased access, convenience, and satisfaction because many of our patients have problems with transportation and job related time constraints. Wait times at the on-site pharmacies will be improved by processing the majority of refill prescriptions with a 24 hour turnaround time at Central Fill. Automation is a proven solution for increasing prescription volumes and is used by the Veterans Administration, public hospitals and retail pharmacy services.

The Harris Health Planning Department is currently searching for a suitable location on our existing property. Lease space has also been given consideration. Project managers will consist of an interdisciplinary team of pharmacy, IT, and planning representatives. Future expansion of the Central Fill model is possible at negligible cost due to the efficiencies gained by automation.

Goals and Relationship to Regional Goals:
Project Goals:

- Develop an in-house central fill facility that can process up to 10,000 prescriptions per day with the capability of increasing volume at a negligible cost.
- Increasing the percentage of prescriptions filled by the central fill facility annually.
- Decreasing the average labor cost per prescription from baseline.
- Engineering pharmacy operations to develop a patient centered delivery model ensuring comprehensive medication management for optimal outcomes.
- Enhancing patient satisfaction by decreasing pharmacy wait times and increasing pharmacy access.
- To become a provider of choice for our patients and for the medically underserved individuals and families of Harris County.
- To offer pharmaceutical services to Regional Healthcare Partners as collaborative agreements are formed.
This project meets the following regional goals:
The central fill project will provide the ability for Harris Health to offer pharmacy services to external Federally Qualified Health Centers (FQHC) and/or other regional healthcare partners as collaborative agreements are formed. The project will also provide increased access and patient satisfaction.

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction. The Harris Health Central Fill will improve efficiency in the pharmacy and improve patient satisfaction with improved wait times and patient adherence.

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system. The Harris Health Central Fill project will allow on site pharmacists to focus on clinical patient centered activities such as Medication Therapy Management, Refill Clinics and lab monitoring. These programs promote patient adherence and wellness as well as decrease emergency room visits for refills.

- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes. Automation technology represents best practices currently in use by the Veterans Administration, the United States Armed Services, as well as other public hospitals and retail pharmacy services. Regional collaboration could include Harris Health acting as a contract pharmacy for our regional healthcare partners.

Challenges:

- Funding – this is addressed by the DSRIP project.
- Site location - the site location will be determined by a committee consisting of pharmacy, planning and security representatives. The site will optimally be on Harris Health property or leased if necessary. The Harris Health Planning Department is actively looking for internal space but has also identified potential external lease space.
- Software operating system - the pharmacy software operating system will be transitioned to Epic by mid DY2 which supports central fill.
- Project development – Due to the large scale nature of the project, the central fill DSRIP project will be supported by a multidisciplinary team including; an Information Technology (IT) project manager, Planning project manager and Pharmacy project manager.

5-Year expected outcome for Provider and Patients:
Through the Central Fill project, Harris Health plans to provide increased efficiency and safety in delivery of pharmaceutical services along with increased access to such services for our patients and regional healthcare partners. Net cost savings are approximately $6.6M through use of automation as compared to the current manual prescription processing. This estimate is based on the current 2.5M prescription volume and will be greater if volume increases with proposed...
clinic expansions.

**Starting Point/Baseline:**
Currently, all prescriptions (approximately 2.5M annually) at Harris Health System are manually filled on site by frontline pharmacy staff with no available automation. Patients either wait for their prescriptions or come back at a later date. Efficiency, safety and access would be greatly enhanced with the creation of a central fill facility with mail order capability.

**Rationale:**

Project option 2.5.4, “Other” project option: Implement other evidence-based project that will impact cost efficiency in an innovative manner, was chosen to justify the pharmacy prescription processing redesign for cost containment. The Harris Health System Department of Pharmacy is committed to providing high quality pharmacy services in the most cost effective and efficient manner through implementation of an in-house central fill facility. The Harris Health System serves approximately 330,000 unduplicated lives, and the Department of Pharmacy currently fills approximately 2.5M prescriptions per year at 16 ambulatory pharmacies located throughout Harris County. Two of the outpatient pharmacies are located within hospitals, and the remaining 14 pharmacies are located within ambulatory clinics. Pharmaceutical services at Harris Health are currently 100% manual. It is expected that approximately 60% of the total Harris Health prescription volume could be efficiently processed by an in-house central fill facility. These medications would consist primarily of maintenance medications for chronic disease conditions. The remaining 40% prescription volume would continue to be filled at the clinic sites and would consist of immediate need medications such as antibiotics, pain medication, antipsychotics, blood pressure and diabetic medications. The in-house central fill processing would afford time for the on-site clinical pharmacists to provide expanded clinical services as physician extenders, such as Medication Therapy Management (MTM), Refill Clinics, and basic lab monitoring. These clinical value added benefits enhance the efficiency and significance of the redesign. Furthermore, the Harris Health System Central Fill Project can easily expand at negligible labor cost to offer pharmaceutical services to our Regional Healthcare Partners as collaborative agreements are formed.

**Project Components:**
This project does not have required components. We will improve efficiencies by increasing the percentage of prescriptions filled at the central fill facility.

- There is currently no automation at Harris Health ambulatory pharmacies, therefore the baseline percentage of prescriptions filled at the central fill facility is 0%
- The first partial year consisting of 6 months central fill processing, ending in DY3, is expected to meet a goal of filling 40% of the total monthly ambulatory prescription volume at the facility. This percentage was chosen based on prior Rx.com central fill reports demonstrating a 36% fill rate at the central fill facility. Additional support is based on the fact that the central fill formulary consists primarily of medications used to treat chronic diseases. Approximately 50% of the total ambulatory prescription volume is for refills, and the majority is chronic disease medications.
• In DY4, the percent of prescriptions filled at central fill will increase by 10% to a goal of 50% over baseline. This will be possible by increasing the central fill formulary, centralizing drug replacement program medications and promoting a central fill awareness campaign.

• In DY5, the percent of prescriptions filled at central fill will increase by 10% to a goal of 60% over baseline. Again, this will be possible by increasing the central fill formulary and increasing central fill awareness.

**Milestones & Metrics:**

- Process Milestones and Metrics: P-X1, P-X1.1; P-7, P-7.1; P-X2, P-X2.1
- Improvement Milestones and Metrics: I-X1, I-X1.1

**Unique Community need identification numbers the project addresses:**

CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including cancer, diabetes, obesity, cardiovascular disease, asthma and AIDS/HIV. The prescriptions filled at the central fill facility are primarily refills for chronic disease conditions. The efficiencies gained with this project will allow pharmacists on site, in the clinics and hospitals, to focus on urgent need prescriptions, e.g. antibiotics, pain, seizure medications. On site clinical pharmacists will also have more time to focus on clinical functions such as Medication Therapy Management (MTM), Refill Clinics and basic lab monitoring.4,5,7

- CN.21 Inadequate transportation options for individuals in rural areas and for indigent/low income populations. The Central Fill project will provide the option for mail order prescriptions. Mail order delivery will enhance access and compliance for our low income patients by relieving transportation, parking and job related issues.2,3,4,5

**RHP priority and starting point**

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

- An in-house central fill facility is a new initiative for Harris Health System. From August 2008 through December 2011 Harris Health participated in an Alternative Method Demonstration Project (AMDP) approved by Health Resources Services Administration (HRSA) to outsource the filling of prescriptions at a central fill in Fort Worth, Texas. Due to software limitations, the AMDP was discontinued and currently all prescriptions are filled on site. The 2 years with the contracted central fill pharmacy has allowed Harris Health to understand the central fill process in regards to formulary management, workflow, regulatory compliance, reports, record keeping, software and hardware requirements. The lessons learned from outsourcing to a central fill facility will ensure a successful creation of an in house central fill facility.

- The robotics in the central fill facility fill approximately 240 prescriptions per hour as compared to 22 prescriptions per hour filled manually on site. Ten thousand prescriptions may be filled per day at the central fill facility with the option to increase capacity at negligible cost.
Related Category 3 Outcome Measure(s):

OD-5 Cost of Care

IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery

The central fill redesign for pharmacy services at Harris Health will result in cost savings through increased efficiencies in the delivery of pharmaceutical services at Harris Healthy System. Automation will help keep labor costs in check while our frontline staff can focus on clinical efforts for our patients. Pharmacists will be readily available for counseling patients on medication adherence. Offering a mail order delivery option will enhance access and compliance for our low income patients by relieving transportation and parking issues.

We will utilize the Cost Benefit Analysis to demonstrate costs and outcomes in monetary units. We propose incremental cost savings as the project goes from zero automation at baseline in DY2 to 60% automation by the end of DY5. We expect to decrease the average labor cost per prescription by 7% by the end of the initial DY3 implementation year. In DY4, we expect a 19% decrease from baseline in the average labor cost per prescription. In DY5, we expect a 31% decrease from baseline in the average labor cost per prescription. We will use a report to be generated from the new software operating system to determine the percentage of prescriptions filled at the central fill facility. The monthly operating statements will be used to show comparative cost savings in total salaries and benefits and the total number of prescriptions filled at Harris Health. Projected cost savings are based on current 2.5M annual prescription volume.

Relationship to other Projects:
The increase of primary care and specialty care will naturally result in additional ambulatory care encounters for our region patient base. The ambulatory initiatives cover items such as laboratory, PT/OT, social work, etc. and are a necessity of our patients to ensure a comprehensive treatment for access as well as cost avoidance. The Region 3 initiative grid in the addendum reflects all ambulatory operations initiatives.

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

Project Valuation:
This project is a supporting pillar for one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in Harris County. The value of the project is based on cost avoidance, projecting savings associated with reducing the costs incurred in filling 2.5 million current patient prescriptions on an annual basis. Based on the increase in primary care volumes addressed in several other Harris Health System Waiver projects, further growth in volume to over 3.0 million prescriptions is projected. Despite this increase in prescription volume, processing costs are projected to decrease in total with the addition of the central fill function. The prompt availability of needed prescriptions for our underserved patients, particularly those with chronic disease that can be managed effectively with appropriate pharmaceuticals, will result in fewer emergency room visits for public and private hospitals located in the service area, and will also help to prevent future downstream inpatient admissions.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>133355104.3.15</th>
<th>IT-5.1</th>
<th>Improved cost savings: Demonstrate cost savings in care delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
<td>2.5.4</td>
<td>N/A</td>
<td>“Other” project option: AMBULATORY CARE CENTRAL FILL PHARMACY</td>
</tr>
<tr>
<td>Milestone 1 [P-X1]: Establish a baseline for percentage of prescriptions processed at central fill facility</td>
<td><strong>Metric 1 [P-X1]:</strong> Implementation of Central Fill Goals:</td>
<td>Complete pharmacy operating system transition to Epic Willow Ambulatory Complete central fill facility build out Go-live at central fill facility</td>
<td><strong>Metric 1 [I-X1]:</strong> Percent increase of prescriptions filled at central fill facility Goal: Increase 40% of total monthly prescription volume from established baseline of 0% prescriptions filled at central fill facility</td>
<td><strong>Metric 1 [I-X1.1]:</strong> Percent increase of prescriptions filled at central fill facility Goal: Increase to 50% of total monthly prescription volume from established baseline of 0% prescriptions filled at central fill facility</td>
</tr>
<tr>
<td>Milestone 2 [P-X2]: Complete a planning process and submit a plan</td>
<td><strong>Metric 1 [P-X2.1]:</strong> Implementation of Central Fill Goals:</td>
<td>Complete pharmacy operating system transition to Epic Willow Ambulatory Complete central fill facility build out Go-live at central fill facility</td>
<td>Data Source: software operating system reports TBD</td>
<td>Data source: Software operating system reports TBD</td>
</tr>
<tr>
<td>Milestone 3 [P-X2]: Complete a planning process and submit a plan</td>
<td><strong>Metric 1 [P-X2.1]:</strong> Implementation of Central Fill Goals:</td>
<td>Complete pharmacy operating system transition to Epic Willow Ambulatory Complete central fill facility build out Go-live at central fill facility</td>
<td>Data Source: software operating system reports TBD</td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
<td>2.5.4</td>
<td>N/A</td>
<td>“Other” project option: AMBULATORY CARE CENTRAL FILL PHARMACY</td>
</tr>
<tr>
<td>Milestone 4 [I-X1]: Increase number of prescriptions filled at central fill</td>
<td><strong>Metric 1 [I-X1.1]:</strong> Percent increase of prescriptions filled at central fill facility Goal: Increase 40% of total monthly prescription volume from established baseline of 0% prescriptions filled at central fill facility</td>
<td>Data source: software operating system reports TBD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
<td>2.5.4</td>
<td>N/A</td>
<td>“Other” project option: AMBULATORY CARE CENTRAL FILL PHARMACY</td>
</tr>
<tr>
<td>Milestone 5 [I-X1]: Increase number of prescriptions filled at central fill</td>
<td><strong>Metric 1 [I-X1.1]:</strong> Percent increase of prescriptions filled at central fill facility Goal: Increase 40% of total monthly prescription volume from established baseline of 0% prescriptions filled at central fill facility</td>
<td>Data source: software operating system reports TBD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
<td>2.5.4</td>
<td>N/A</td>
<td>“Other” project option: AMBULATORY CARE CENTRAL FILL PHARMACY</td>
</tr>
<tr>
<td>Milestone 6 [I-X1]: Increase number of prescriptions filled at central fill</td>
<td><strong>Metric 1 [I-X1.1]:</strong> Percent increase of prescriptions filled at central fill facility Goal: Increase 40% of total monthly prescription volume from established baseline of 0% prescriptions filled at central fill facility</td>
<td>Data source: software operating system reports TBD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 7 [P-7]: Participate in at least biweekly interactions with other providers and the RHP to promote collaborative learning around solutions or similar projects. This will include 1) sharing challenges and solutions 2) sharing results and quantitative progress on new improvements and 3) identifying new improvements and publicly committing to testing in the week to come.</td>
<td><strong>Metric 1 [P-7.1]:</strong> Participate in one biweekly meeting, conference call or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 8 [I-X1]: Increase number of prescriptions filled at central fill</td>
<td><strong>Metric 1 [I-X1.1]:</strong> Percent increase of prescriptions filled at central fill facility Goal: Increase to 50% of total monthly prescription volume from established baseline of 0% prescriptions filled at central fill facility</td>
<td>Data source: software operating system reports TBD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 9 [P-7]: Participate in at least biweekly interactions with other providers and the RHP to promote collaborative learning around solutions or similar projects. This will include 1) sharing challenges and solutions 2) sharing results and quantitative progress on new improvements and 3) identifying new improvements and publicly committing to testing in the week to come.</td>
<td><strong>Metric 1 [P-7.1]:</strong> Participate in one biweekly meeting, conference call or</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan

Region 3

1117
<table>
<thead>
<tr>
<th>133355104.2.1</th>
<th>2.5.4</th>
<th>N/A</th>
<th>“Other” project option: AMBULATORY CARE CENTRAL FILL PHARMACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>HARRIS HEALTH SYSTEM</td>
<td></td>
<td></td>
<td>133355104</td>
</tr>
</tbody>
</table>

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

| 133355104.3.15 | IT-5.1 | Improved cost savings: Demonstrate cost savings in care delivery |

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: project coordinators</td>
<td>Milestone 4 Estimated Incentive Payment: $2,493,654.33</td>
<td>webinar organized by the RHP Goal: Bi-weekly meetings Data Source: Minutes</td>
<td>webinar organized by the RHP Goal: Bi-weekly meetings Data Source: Minutes</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $3,428,658</td>
<td><strong>Milestone 5</strong> [P-7]: Participate in at least biweekly interactions with other providers and the RHP to promote collaborative learning around solutions or similar projects. This will include 1) sharing challenges and solutions 2) sharing results and quantitative progress on new improvements and 3) identifying new improvements and publicly committing to testing in the week to come.</td>
<td>Milestone 7 Estimated Incentive Payment: $3,751,355</td>
<td>Milestone 9 Estimated Incentive Payment: $3,098,945.50</td>
</tr>
<tr>
<td>Metric 1 [P-7.1]: Participate in one biweekly meeting, conference call or webinar organized by the RHP Goal: Bi-weekly meetings Data Source: Minutes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 5 Estimated Incentive Payment: $2,493,654.33</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount:** $6,857,316  
**Year 3 Estimated Milestone Bundle Amount:** $7,480,963  
**Year 4 Estimated Milestone Bundle Amount:** $7,502,710  
**Year 5 Estimated Milestone Bundle Amount:** $6,197,891

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over DYs 2-5): $28,038,880
Appendix A: References

3) Los Angeles County Board of Supervisors. Approval of Sole Source Agreement for Pharmacy Central Fill Services with Cardinal Health Pharmacy Services, LLC. Los Angeles County, CA: Dept. of Health Services; 2012.
Project Option 2.9.1- Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: Reduce ER Utilization for Top Frequenters

**Unique RHP Project ID:** 133355104.2.2 / Pass 1

**Performing Provider Name/TPI:** Harris Health System / 133355104

**Project Summary:**

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

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

**Volume Statistics - FY2012**

**Patient Payor Mix**

**Patient Demographics**

Intervention(s):
This project will target top EC frequenters and ensure they are managed appropriately to receive the right care in the right setting through a navigation program.

Need for the project:
In 2010, more than 40% of Harris County ER visits by Harris County residents were primary care related, these include visits for conditions that are non-urgent, primary care treatable, and primary care preventable.

Target Population:
Any patient seeking care in the EC for primary care-treatable conditions may benefit from this project. The patient impact will focus on a continuous rolling cohort of the top 100 ER frequenters. (Overall Payor Mix: Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

**Category 1 or 2 expected patient benefits:**
Our goals are to increase the percent of patients without a PCP who receive an appointment from the EC and increase the percent of patients with a PCP who receive an appointment from the EC by 10% in DY4 and 20% in DY5. The program will target the top 100 most frequent ER utilizers by DY5.

**Category 3 outcomes:**
IT-9.4: Our goal is to reduce ER utilization rate for frequent user cohort by 10% in DY4 and 20% in DY5.
Project Option 2.9.1- Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: Reduce ER Utilization for Top Frequenters

**Unique RHP Project ID:** 133355104.2.2 / Pass 1
**Performing Provider Name/TPI:** Harris Health System / 133355104

**Project Description:**
*Harris Health System proposes a project that will target top EC frequenters and ensure they are managed appropriately to receive the right care in the right setting.*

Harris Health aims to ensure patients receive appropriate care in the appropriate setting by identifying the cohort of highest EC frequenters at Ben Taub Hospital and Lyndon B. Johnson Hospital. This will allow targeted implementation of personalized management plan for more appropriate utilization of medical services and has been demonstrated to provide significant cost savings. A social worker and nurse will establish a baseline assessment of each patient identified in the cohort. The social worker will contact the patient by telephone. If the attempts are unsuccessful, the patient will be met at the next emergency center visit. During the initial contact the social worker, nurse and patient will create a plan to improve the patient’s access to care and disease management. The social worker will contact the patient at mutually agreed upon intervals to monitor the patient’s progress.

4.0 full-time equivalent (FTE) social workers will be required to initiate the program (2.0 FTEs at Ben Taub and 2.0 FTEs at LBJ), which will expand to 8.0 FTE by DY5. 2.0 FTE nurses (1.0 at Ben Taub and 1.0 at LBJ) will be required to initiate the program. This will expand to 4.0 FTEs by DY5. These FTEs will be divided between Ben Taub Hospital and Lyndon B Johnson Hospital. Some physician oversight will be required. 0.5 physician FTEs (at each Pavilion for a total of 1.0), to be allocated at each hospital between Emergency Medicine and Family Medicine, will be required to initiate the program. This will grow to 1.5 FTE by DY5 (at each Pavilion).

**Goals and Relationship to Regional Goals:**

**Project Goals:**
The goal of this project is to identify the top ER Frequenter cohort and implement personalized management plans in order to decrease annual rate of ER usage for these patients. This project supports the region’s goal to ensure patients receive the most appropriate care for their conditions.

This project addresses the following regional goals:
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.
**Challenges:**
Top ER users suffer high rates of social dysfunction, substance abuse, and psychiatric dysfunction, creating disease management challenges. Barriers to managing a chronic disease include: access to a primary care physician, transportation to routine health care visits, homelessness, lack of personal identification, health care literacy, and medication side effects.

**5-Year Expected Outcomes:**
Marked decrease in ER usage for the patient cohort is expected. Additionally, Harris Health expects to realize significant cost savings and improved clinical outcomes.

**Baseline:**
The navigation program does not yet exist; baseline data will be identified in DY2 and DY3 as appropriate.

**Rationale:**
ER usage by top frequenters represents a markedly disproportionate percent of ER and hospitalization costs. Careful navigation services that establish patient trust in the healthcare system can reduce utilization of emergency services and reduce costs significantly.\(^1\) In 2010, over 40% of Harris County ER visits by Harris County residents were primary care related, these include visits for conditions that are non-urgent, primary care treatable, and primary care preventable. The average cost to treat these patients in the ER at Harris Health System versus a primary care setting was approximately $800 per visit for all age groups. The proposed navigation program will help patients access ongoing chronic care in appropriate settings, which can significantly decrease the cost of care for those patients.

**Project Components:**
Harris Health will meet the required project components:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency. A needs assessment will be conducted in DY1 to determine the appropriate structure of the program (P-1). Navigators will be trained in DY2. Training will include cultural competency components (P-2).

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators. Case managers will be trained and deployed in DY2 (P-2).

c) Connect patients to primary and preventive care. As one of the core components of the program, case managers will help patients obtain primary care appointments (I-6).

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management. This will be completed as part of the development of the patient’s individualized care plan.

e) Conduct quality improvement for the project, including identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population,

---

and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. A follow-up needs assessment will be completed in DY4 to determine if the program is meeting the patients’ needs. Improvements identified through the needs assessment will be implemented by DY5 (P-1).

**Milestones and Metrics:**
The following milestones and metrics have been selected based on the population needs:
- Process Milestones and Metrics: P-1 (P-1.1), P-2 (P-2.1)
- Improvement Milestones and Metrics: I-6 (I-6.4, I-6.5)

**Unique Community Needs Identification Number:**
This project addresses the following community needs as identified by the region:
- CN4 – Absence of care coordination for chronic conditions
- CN12 – Improved access to patient education and information
- CN13 – Improved services and access to care for the homeless population
- CN14 – Reduction in inappropriate emergency department utilization

**How the project represents a new initiative for the Performing Provider:**
Patient navigation services do not currently exist for frequent ER users. This initiative will improve access to coordinated care for patients who most need it.

**Related Category 3 Outcome Measure:**
OD-9 Right Care, Right Setting
IT-9.4 Other Outcome Improvement Target – ED Appropriate Utilization

**Reasons/rationale for selecting the outcome measures:**
In 2010, over 40% of Harris County ER visits by Harris County residents were primary care related, these include visits for conditions that are non-urgent, primary care treatable, and primary care preventable. The average cost to treat these patients in the ER versus a primary care setting was approximately $800 per visit for all age groups. Connecting patients who frequent the ER with consistent, coordinated primary and specialty care access will improve clinical outcomes, which will decrease the need to access emergent services.

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

**Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.
**Project Valuation:**
This project will identify the highest utilizers of emergency room services in the Harris health System, and implement personalized navigation and management plans in order to decrease the annual rate of usage for these patients. The value of the project is based on cost savings associated with a substantial reduction in the utilization of emergency services, as well as helping to prevent future downstream inpatient admissions that frequently occur in this population. While the initial focus will begin with the top 100 patients, as the program expands we will drill further into the emergency room population and enroll more patients, as appropriate.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure:</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>133355104.3.16</td>
<td>133355104.3.16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>133355104.2.2</strong></td>
<td><strong>2.9.1</strong></td>
<td><strong>(A-D)</strong></td>
<td><strong>PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE: REDUCE ER UTILIZATION FOR TOP FREQUENTERS</strong></td>
<td><strong>Region 3</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Harris Health System</strong></td>
<td><strong>133355104</strong></td>
<td><strong>Reduce ER Visits for Frequent User Cohort</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 1 [P-1]:** Conduct needs assessment  
**Metric 1 [P-1.1]:** Provide needs assessment  
Goal: Submission of report  
Data Source: Performing provider report  
Milestone 1 Estimated Incentive Payment: $3,130,732

**Milestone 2 [P-2]:** Establish navigation program  
**Metric 1 [P-2.1]:** Number of people trained as navigators  
Goal: Train 2 navigators  
Data Source: Workforce development plans  
Milestone 2 Estimated Incentive Payment: $1,707,730

**Milestone 3 [I-6]:** Percent of patients who are given a scheduled PCP appointment  
**Metric 1 [I-6.4]:** Percent of patients without a PCP who receive an appointment  
Goal: Establish baseline from cohort of 100 patients  
Data Source: Administrative and scheduling data  
Milestone 3 Estimated Incentive Payment: $1,707,730

**Milestone 4 [P-1]:** Conduct follow-up needs assessment  
**Metric 1 [P-1.1]:** Provide ongoing needs assessment  
Goal: Submission of report  
Data Source: Performing provider report  
Milestone 4 Estimated Incentive Payment: $114,796.33

**Milestone 5 [P-2]:** Expand navigation program  
**Metric 1 [P-2.1]:** Number of people trained as navigators  
Goal: Train 2 additional navigators  
Data Source: Workforce development plans  
Milestone 5 Estimated Incentive Payment: $114,796.33

**Milestone 6 [I-6]:** Percent of patients who are given a scheduled PCP appointment  
**Metric 1 [I-6.4]:** Percent of patients without a PCP who receive an appointment  
Goal: Increase by 10% over baseline  
Data Source: Administrative and scheduling data  
Milestone 6 Estimated Incentive Payment: $2,829,669

**Milestone 7 [I-6]:** Percent of patients who are given a scheduled PCP appointment  
**Metric 1 [I-6.4]:** Percent of patients without a PCP who receive an appointment  
Goal: Increase by 20% over baseline  
Data Source: Administrative and scheduling data  
Milestone 7 Estimated Incentive Payment: $2,829,669
<table>
<thead>
<tr>
<th>133355104.2.2</th>
<th>2.9.1</th>
<th>(A-D)</th>
<th><strong>PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE: REDUCE ER UTILIZATION FOR TOP FREQUENTERS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Harris Health System</td>
<td>133355104</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Related Category 3**  
**Outcome Measure:**  
133355104.3.16 | IT-9.4 | **Reduce ER Visits for Frequent User Cohort** |

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

- **Metric 2** [I-6.5]: Percent of patients with a PCP who receive an appointment
  - **Goal:** Increase by 10% over baseline
  - **Data Source:** Administrative and scheduling data

- **Milestone 6 Estimated Incentive Payment:** $114,796.33

| Year 2 Estimated Milestone Bundle Amount: $3,130,732 | Year 3 Estimated Milestone Bundle Amount: $3,415,460 | Year 4 Estimated Milestone Bundle Amount: $3,425,389 | Year 5 Estimated Milestone Bundle Amount: $2,829,669 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over DYs 2-5): $12,801,250

Regional Healthcare Partnership Plan
Region 3

1126
Project Option 2.8.6- Reduce Inappropriate ED Use: Emergency Center Advanced Triage Care

Unique RHP Project Identification Number: 133355104.2.3 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

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

Volume Statistics - FY2012

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

Intervention(s):
This project will improve emergency center throughput and reduce inappropriate use of emergency centers in the system through the implementation of a provider-in-triage model.

Need for the project:
In 2010, more than 40% of Harris County ER visits by Harris County residents were primary care related, these include visits for conditions that are non-urgent, primary care treatable, and primary care preventable.

Target Population:
All patients within the system seeking care in the ER for primary-care for treatable conditions may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%). From January-September 2012, Harris Health saw 3,484 ESI 4 and ESI 5 patients combined.

Category 1 or 2 expected patient benefits:
Our goal is to decrease average length-of-stay in the ER for ESI levels 4 and 5 by 1% compared to baseline in DY3, by 3% in DY4, and by 5% in DY5. We also aim to increase the number of patients seen through advanced triage model from 1,000 in DY3 to 3,000 by DY5.

Category 3 outcomes:
IT-9.4: Other Outcome Improvement Target: Our goal is to reduce left without being seen (LWBS) rates for ESI level 4 and 5. We will establish a baseline in DY3, to begin measuring improvement in DY4 and DY5.
Project Option 2.8.6- Reduce Inappropriate ED Use: Emergency Center Advanced Triage Care

**Unique RHP Project Identification Number:** 133355104.2.3 / Pass 1  
**Performing Provider Name/TPI:** Harris Health System / 133355104

**Project Description:**

*Harris Health System proposes a project to improve emergency center throughput and reduce inappropriate use of emergency centers in the system.*

In an effort to improve emergency center (ED) throughput, many emergency departments have placed physicians in the triage area. EMTALA mandates that all patients presenting to an Emergency Department be provided a medical screening exam to determine if an "emergency medical condition" exists that would require further evaluation and treatment. In the provider-in-triage model, a physician has the opportunity to provide this medical screening exam and determine if the patient should continue to receive care in the emergency department, or if the best care setting for the patient's condition would be at another care location (primary care office, urgent care center, etc.). Patients whose conditions can be treated appropriately in an outpatient clinic setting will be referred to a proximate same day outpatient clinic. In the event that a patient requires further care in the ED, the provider will initiate diagnostic testing (laboratory and imagining) while the patient returns to the waiting room. When the patient is evaluated later, testing should be completed, facilitating faster disposition.

Specific MD FTEs will be dedicated to triage screening at each hospital of Harris Health System, Ben Taub Hospital and Lyndon B. Johnson Hospital, for the success of this project.

**Goals:**

**Project goals:**
- Improving patient throughput times
- Improving efficiency by helping patients with non-urgent conditions receive appropriate care in the appropriate setting

This project addresses the following regional goals:
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system

**Challenges:**

There are concerns regarding adding additional providers to a defined space in the triage area. ED redesign will be occurring during this timeline as well. At Ben Taub, we have identified a
physical space in our triage area where the provider can work. We will ensure that during the renovation that this space is conserved and the process can continue. Same is true for LBJ General Hospital.

5-Year Expected Outcomes for Provider and Patients:
Improve throughput times of ED patients who meet emergency severity index (ESI) level 3-5 criteria. Increase the number of patients referred to proximate same day clinics.

Starting Point/Baseline:
Average length of stay and number of patients per month by ESI level, January-September 2012:

**Ben Taub Hospital:**
- ESI 4 = 473 minutes (7.9 hours); 1,466 patients
- ESI 5 = 395 minutes (6.6 hours); 579 patients

**Lyndon B. Johnson Hospital:**
- ESI 4 = 568 minutes (9.5 hours); 1,274 patients
- ESI 5 = 494 minutes (8.2 hours); 165 patients

Rationale:
In 2010, more than 40% of Harris County ED visits by Harris County residents were primary care related, these include visits for conditions that are non-urgent, primary care treatable, and primary care preventable. The average cost to treat these patients in the ED versus a primary care setting was approximately $800 per visit for all age groups. Referring patients with primary care treatable conditions to proximate same day clinics and health centers can help to reduce costs of care for the affected individual patients, freeing resources and improving efficiency for patients who need emergent care.

Placing a physician in triage will allow patients to receive medical screening before occupying an ED bed. Studies have shown that effectively positioning a physician in triage can decrease the time spent in an ED bed.¹ Several advanced triage models (e.g. nurse-led teams) have proven effective but are wrought with opportunities to mistake subtle complaints or symptoms for a non-emergency and allow acutely ill patients to wait prolonged times for treatment. Optimal patient safety supports a physician at triage ensuring expedient evaluation, appropriate diagnostic work-up and treatment². Thus, by implementing a physician in triage model, we expect to improve efficiency while maintaining high quality standards of care.

Project Components:
There are no required project components for option 2.8.6.

¹ Russ S, Jones I, Aronsky D, Dittus RS, Slovis CM. Placing physician orders at triage: the effect on length of stay.
Milestones & Metrics:
- Process Milestones and Metrics: P-4 (P-4.1), P-10 (P-10.1), P-12 (P-12.1)
Number of patients reached through advanced triage (progress toward goal) and length of stay (efficiency) are the selected improvement metrics. Metrics will be measured per hospital to account for variations in patient populations.

Unique Community Needs Identification Number:
- CN14 – Reduction in inappropriate emergency department utilization

How the project represents a new initiative for the Performing Provider:
Harris Health currently does not position physicians in the triage area. This initiative will improve ED efficiency and lengths of stay.

Related Category 3 Outcome Measures:
OD-9 Right Care, Right Setting
IT-9.4 Other Outcome Improvement Target – Reduce Left Without Being Seen (LWBS) rate for ESI Level 4 and 5 patients. **Reasons/rationale for selecting the outcome measures:**

In 2010, over 40% of Harris County ED visits by Harris County residents were primary care related, these include visits for conditions that are non-urgent, primary care treatable, and primary care preventable. The average cost to treat these patients in the ED versus a primary care setting was approximately $800 per visit for all age groups. Referring patients with primary care treatable conditions to proximate walk-in clinics can help to reduce costs of care for the affected individual patients, freeing resources and improving efficiency for patients who need emergent care. The number of patients who leave the EC prior to contact with a provider is identified as the left without being seen rate (LWBS). The Harris Health System plans to implement a physician-in-triage model to address these challenges.

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

---

3 School of Public Health, *Houston Hospitals Emergency Department Use Study: January 1, 2010 through December 31, 2010*, Houston, Texas: University of Texas Health Science Center at Houston, 2012.
**Plan for Learning Collaborative:** We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

**Project Valuation:**
This project will improve patient throughput times for patients appropriately utilizing emergency room services, and improve the overall efficiency of the healthcare system by helping patients with non-urgent conditions receive appropriate care in a more cost effective setting. The value of the project is based on cost savings associated with a reduction in the utilization of emergency services by non-urgent patients. Referring patients with primary care treatable conditions to proximate same day clinics and health centers can also help to reduce costs of care for the affected individual patients, freeing resources and improving efficiency for patients who need emergent care.
<table>
<thead>
<tr>
<th>Related Category</th>
<th>Outcome Measure(s):</th>
<th>133355104.3.17</th>
<th>IT-9.4</th>
<th>Reduce LWBS rates for ESI 4 and 5 patients</th>
</tr>
</thead>
</table>

**Year 2**  
(10/1/2012 – 9/30/2013)

**Milestone 1 [P-4]:** Define operational procedures to improve efficiencies

**Metric 1 [P-4.1]:** Report at least two new procedures (medical screening and advanced triage care) to improve care management efficiency

  - Goal: Submission of analysis  
  - Data Source: Performing Provider report

**Milestone 2 Estimated Incentive Payment:** $2,455,947

**Year 3**  
(10/1/2013 – 9/30/2014)

**Milestone 2 [P-10]:** Develop a quality dashboard

**Metric 1 [P-10.1]:** Submission of dashboard development, utilization and results

  - Goal: Submission of dashboard  
  - Data Source: EHR, policies and procedures, sample report

**Milestone 2 Estimated Incentive Payment:** $1,339,653

**Year 4**  
(10/1/2014 – 9/30/2015)

**Milestone 4 [P-12]:** Report findings and learnings

**Metric 1 [P-12.1]:** Report summary

  - Goal: Submission of analysis  
  - Data Source: Performing Provider report

**Milestone 4 Estimated Incentive Payment:** $895,698.33

**Year 5**  
(10/1/2015 – 9/30/2016)

**Milestone 7 [I-13]:** Progress toward target

**Metric 1 [I-13.1]:** Number or percent of all clinical cases that meet target/goal

  - Goal: 3,000 total patients seen through advanced triage model  
  - Data Source: EHR

**Milestone 7 Estimated Incentive Payment:** $1,109,887

**Milestone 8 [I-14]:** Measure efficiency

**Metric 1 [I-14.1]:** Decrease average length of stay

  - Goal: Decrease average LOS for ESI Level 4 and 5 by 5% compared to baseline  
  - Data Source: EHR

**Milestone 8 Estimated Incentive Payment:** $1,109,887
### Reduce Inappropriate ED Use: Emergency Center Advanced Triage Care

**Harris Health System**

**133355104.2.3**

**2.8.6**

N/A

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>133355104.3.17</td>
<td>IT-9.4</td>
</tr>
</tbody>
</table>

**Reduce LWBS rates for ESI 4 and 5 patients**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>

**Milestone 6 [I-14]: Measure efficiency**

**Metric 1 [I-14.1]: Decrease average length of stay**

- Goal: Decrease average LOS for ESI Level 4 and 5 by 3% compared to baseline
- Data Source: EHR

Milestone 6 Estimated Incentive Payment: $895,698.33

| Year 2 Estimated Milestone Bundle Amount: $2,455,947 | Year 3 Estimated Milestone Bundle Amount: $2,679,306 | Year 4 Estimated Milestone Bundle Amount: $2,687,095 | Year 5 Estimated Milestone Bundle Amount: $2,219,774 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5): $10,042,122*
Harris County Hospital District Ben Taub General Hospital Pass 3
Project Option 2.9.1- Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: OB Navigation Program

Unique RHP Project Identification Number: 133355104.2.4 / Pass 3
Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

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

Volume Statistics - FY2012

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

Intervention(s):
This project will improve access to pre- and postnatal care through comprehensive, effective patient navigation through the Harris Health System and throughout a woman’s pregnancy, with a focus on high-risk mothers.

Need for the project:
Harris County had 68,167 births in 2010. In FY2012, Harris Health delivered 6,643 babies. The Healthy People 2020 goal for low birth-weight births is 7.8%, while the percentage of low birth-weight births at the Harris Health System for 2011 was 9.9%.

Target Population:
Potential prenatal care patients across the county and within the system will be targeted. (2009 Harris Health Delivery Payor Mix: Medicaid- 62%/ Self-Pay and Indigent- 33%).

Category 1 or 2 expected patient benefits:
Our goal is to enroll 200 unique pregnant women in DY3, 600 in DY4 and 1250 in DY5. The team aims to serve 2,050 unique pregnant women by DY5 (DY3-DY5).

Category 3 outcomes:
IT-8.2: In DY4, of those patients who received the intervention, decrease the percentage of babies born weighing <2,500 grams to less than DY3 percentage. DY5 is goal to be determined.
Project Option 2.9.1- Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: OB Navigation Program

**Unique RHP Project Identification Number:** 133355104.2.4 / Pass 3  
**Performing Provider Name/TPI:** Harris Health System / 133355104

**Project Description:**
We propose a project that would improve access to pre- and postnatal care through comprehensive, effective patient navigation through the Harris Health System and throughout a woman’s pregnancy. The Harris Health System will be the performing provider. Navigation efforts will be aimed at overall improved birth outcomes for Harris Health System obstetrics patients, such as increased gestational age and birth weight, and low infant and maternal mortality rates. However, specific improvement targets are described in the table and in Category 3 measure documents.

Funding for the OB Navigation Program will provide for a collaborative team of Navigators to include Community Health Workers (CHWs), Case Managers (CMs), Social Workers (SWs), and Nurses, who will be responsible for navigating high-risk mothers through the healthcare system throughout their pregnancy and to their postpartum appointment. The care team will be spread to cover all 13 facilities that provide obstetrics care in the Harris Health System. The care team will be responsible for recruiting women into prenatal care across the system and will route those patients through to postpartum care. They may also route existing obstetrics patients into postpartum care and subsequent primary care in a medical home. Through encounters in the medical home setting and with navigators, chronic conditions can also be addressed through patient education opportunities at health centers and access to chronic disease management programs. Internal efforts through P-1 in DY2 will produce a plan detailing the specific target population, size and skill mix of the care team needed, and additional strategies that will be used to manage and capture the target population.

Strategic areas within Harris Health System to enroll women will include facilities offering free pregnancy testing, the postpartum and NICU inpatient units, and the Emergency Departments. The University Of Texas School Of Public Health’s 2009 ED analysis of primary care visits to the ED revealed that of the top 20 primary care related diagnosis in the 18-24 year old age Medicaid group, the top 3 diagnoses were for pregnancy related conditions. Moreover, a total of 7 of the 20 overall were pregnancy related diagnoses. P-5 in DYs 4 and 5 will report on the navigation services occurring in the EDs.

In the community, CHWs will engage women at external venues, such as apartment complexes, community centers, and local businesses. The team will ensure proper access to care, appointment scheduling, Medicaid/CHIP enrollment, and will use targeted outreach strategies and health education to reach patients early in pregnancy, especially when patients are at risk of leaving the care of Harris Health System. Once enrolled, patients will receive follow-up phone calls, appointment reminders, case management services, education, and support from Navigators to ensure that patients continue prenatal care, delivery, and postpartum follow-ups. For the purposes of Improvement Milestone I-12 measurement, the definition of “enrolled” will be established in DY2. Navigators will hand patients off to the care of a primary care provider after the postpartum visit. Improvement milestones and goals in DY4 and DY5 concentrate on increasing the number of unique patients enrolled in the program. While accurate data collection issues will be addressed in DY2, reports from the Harris Health System EMR indicate that an
average of approximately 600 OB Screening visits are completed each month across all Harris Health System health centers. An OB Screening visit indicates a recent positive pregnancy test. Using the current volume of OB Screening visits, a 10% increase in DY4 over the baseline number of patients enrolled in DY3 is a reasonable goal, irrespective of when enrollment begins in DY3. Furthermore, the goal of a 15% increase over baseline in DY5 is a reasonable expectation as lessons learned in DY4 will enhance outreach and enrollment efforts.

Targeted, “high-risk” mothers will exhibit risk factors relating to medical conditions, previous pre-term birth experience, and/or other socio-economic and psychosocial risk factors. Each of the Harris Health System health centers are located in areas of the community with populations at high-risk of delivering with poor outcomes. Navigators will use the EPIC EMR to collect data and document patient encounters.

Harris Health System proposes to target zip codes in Harris County with the poorest perinatal outcomes, including: highest rates of pre-term birth, low birth weight, and infant and maternal mortality. In addition, these areas exhibit low rates of entry into prenatal care during the first trimester. These areas coincide with areas of low-income poor socio-economic status. This data is currently available from the State and internal sources at Harris Health System and is reliable. By comparing the zip codes to Harris Health System care locations, it becomes clear that all health centers are strategically located to serve the high-risk, pregnant population.

Target Zip Codes:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>77003</td>
<td>77021</td>
<td>77033</td>
<td>77048</td>
<td>77072</td>
<td>77082</td>
<td>77091</td>
<td>77520</td>
<td></td>
</tr>
<tr>
<td>77004</td>
<td>77022</td>
<td>77036</td>
<td>77051</td>
<td>77073</td>
<td>77083</td>
<td>77093</td>
<td>77521</td>
<td></td>
</tr>
<tr>
<td>77013</td>
<td>77026</td>
<td>77038</td>
<td>77053</td>
<td>77074</td>
<td>77086</td>
<td>77092</td>
<td>77530</td>
<td></td>
</tr>
<tr>
<td>77016</td>
<td>77028</td>
<td>77040</td>
<td>77054</td>
<td>77077</td>
<td>77088</td>
<td>77099</td>
<td>77562</td>
<td></td>
</tr>
<tr>
<td>77018</td>
<td>77031</td>
<td>77045</td>
<td>77067</td>
<td>77078</td>
<td>77090</td>
<td>77338</td>
<td>77587</td>
<td></td>
</tr>
<tr>
<td>77020</td>
<td>77032</td>
<td>77047</td>
<td>77071</td>
<td>77081</td>
<td>77506</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

The goal of this project is to utilize community health workers, case managers, social workers, and nurses as a comprehensive patient navigation team that will provide enhanced care coordination, community outreach, social support and culturally competent care to high-risk obstetrics patients throughout their pregnancy. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators may assist in connecting patients to Ob care providers in Harris Health medical home sites, as well as diverting non-urgent obstetrics care from the Emergency Department (ED) to site-appropriate locations.

Project Goals:

- Increase the number of unique pregnant women served by the OB Navigation program.
- Decrease percentage of low birth-weight births among patients who complete the program and deliver at Harris Health System.

This project meets the following Region 3 goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and
Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

The OB Navigation program uses a patient-centered, coordinated care navigation model that aims to improve perinatal outcomes, improve satisfaction through timely access to appropriate care, and builds on the existing, successful network of Harris Health prenatal care access points. The program leverages the existing Harris Health prenatal care infrastructure to meet the need for increased enrollment in prenatal care with the goal of improving the poor perinatal outcomes currently exhibited in Harris County.

Challenges:
Currently, local data illustrates that perinatal outcomes in Harris County remain poor, despite boasting a world-renowned medical center. Harris County’s preterm birth rates (13.3%), low birth weight rates (8.8 %), infant mortality (6.3/1000 live births), fetal mortality (6.2 1000 live births plus fetal deaths) and maternal mortality (21.4/100,000 live births)1 are all higher than the Healthy People 2020 goal. Since 2005, there has also been a steady decline in first trimester prenatal care in Harris County (62% of births, compared to only 52.4% in 2010). Cultural and social determinants that are difficult to overcome contribute to Harris County’s poor outcomes. The Ob navigation program will attempt to address this challenge through targeted, concerted outreach efforts to patients at high-risk of experiencing poor perinatal outcomes and entering prenatal care late.

5-Year Expected Outcome for Provider and Patients:
Harris Health System expects to see improvements in perinatal outcomes, specifically related to birth-weight births, for patients completing the program and delivering within the Harris Health System. Expected outcomes will relate to the project goals described above.

Starting Point/Baseline:
Currently, a patient navigation program does not exist for obstetrics patients at the Harris Health System. Therefore, the baseline will be set at 0 for DY1-2. A quantifiable goal for serving patients (200 unique pregnant women) is included in DY3, Milestone 4.

Rationale:
Reasons for selecting the project option:
Patient navigators will help patients and their families navigate the complex Harris Health System. The OB Navigation team will include: Community Health Workers (CHWs), Case Managers (CMs), Social Workers (SWs), and Nurses. Patient navigators will be chosen based on their ability to be compassionate, culturally competent, and knowledgeable about the health care setting.

An Ob navigation team is needed in the Harris County community. Harris County has had an average of 71,000 births per year since 2005 (5.6% of Texas births), with 68,167 births in 2010. Harris County’s low birth weight rate (8.8 %) for the same year is higher than the Healthy People 2020 goal of 7.8% and higher than the 2010 national average of 8.15%. Moreover, the percentage of low birth-weight births at the Harris Health System (LBJ General Hospital and Ben Taub General Hospital combined) for 2011 was 9.9%. While this project is targeting low
birth-weight percentages for the selected Category 3 outcome measure, it is important to note that Harris County performs poorly across many perinatal outcome measures.

In 2010, Harris County’s preterm birth rate was 13.3% (9,096 pre-term babies). This rate has decreased slightly since 2005 (13.7%), yet remains above the national rate of 11.99% and the Healthy People 2020 goal of 11.4%. Within Harris County, there are great disparities regarding preterm birth rates; zip-code level data shows preterm birth rates ranging from 3.8% to 19.8%.

Since 2005, there has been a steady decline in first trimester prenatal care in Harris County (62% of births, compared to only 52.4% in 2010). Zip-code data identify disparities within the county, with rates for first trimester prenatal care ranging from 32.8% to 74.2%. Approximately 3.8% of the births in 2010 received no prenatal care. Births with no prenatal care range from 0 to 10% at the zip-code level.

The infant mortality rate in 2010 was 6.3/1,000 live births, which is above the Healthy People 2020 goal of 6.0/1,000 live births. Fetal mortality is high as well, at 6.2/1,000 live births plus fetal deaths, placing our rates above the Healthy People 2020 goal of 5.6/1,000 live births plus fetal deaths. Entering in to care early in pregnancy allows for accurate dating of pregnancy, identifying and treating health risk factors for the mother, and providing education. This is especially important as about 39% of women in Harris County are uninsured prior to pregnancy and a high proportion of women responding to the Pregnancy Risk Assessment Monitoring System questionnaire women reported suboptimal preconception health. Early identification of women with a previous preterm birth enables interventions to potentially prevent a subsequent preterm birth.

By comparing the attached maps, which include markers where Harris Health System health centers are located as well as our target zip codes (listed above), it becomes clear that all health centers are strategically located to serve the high-risk, pregnant population.

**Project Components:**

As the performing provider, Harris Health System proposes to meet all required project components listed below and believe that the selected milestones and metrics relate to project components.

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency. The navigation team will use the ED (within Harris Health System) as contact point to engage pregnant women. Milestones 7 and 10 in DYs 4 and 5 will measure the navigation services provided to women the EDs at Ben Taub and LBJ General Hospitals. Cultural competency is not only part of required training for all Harris Health employees, but will also be a necessary skill for all members of the navigation team upon hiring.

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators. Milestones 2 and 3 in DY3 focus on the hiring and training of health professionals for this program, including: Case Manager, Social Workers, Community Health Workers, and Nurses.

c) Connect patients to primary and preventive care. While typically at the end of the navigation cycle, the connection from prenatal to postnatal and primary care is an integral part of the navigation team’s duties. Patients will be connected postnatal and primary care after delivery and during their pregnancy, as needed. As an established Harris Health patient, mothers will be quickly routed to their medical home.
d) **Increase access to care management and/or chronic care management.** As an established Harris Health patient, mothers will be quickly routed to their medical home. Many times, their prenatal care provider will be in the same facility as their primary care medical home. In the medical home, patients will find access to chronic disease management, care management, and education, as needed.

e) **Conduct quality improvement for project using methods such as rapid cycle improvement.** At a higher level, we will participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around similar navigation and obstetric-focused projects (DY3,4,5). At the ground level, we will monitor a consistent set of agreed-upon, evidence-based metrics to measure the effectiveness of the navigation program, both operationally and regarding outcomes. As opportunities for improvement are found, we will implement quality improvement processes and/or projects in partnership with our Quality Management Services department.

Patients will experience a hand-off to a primary care provider after the postpartum visit. If patients should need chronic care management or other treatment, a primary care visit will be scheduled. In addition, all preventive care needs will be met by the medical home.

**Milestones & Metrics:**
The following milestones and metrics have been chosen for the OB Navigation Program project based on the core components and the needs of the target population:

- Process Milestones and Metrics: P-1 (P-1.1); P-2 (P-2.1); P-5 (P-5.1); P-X (P-X.1); P-8 (P-8.1);
- Improvement Milestones and Metrics: I-10 (I-10.3)

Customizable Improvement Milestones and Metrics were chosen in order to specifically tailor their intent to target the Ob population.

**Unique community need identification number the project addresses:**
The project addresses the following unique community needs as identified in the community needs assessment:

- CN.8- High rates of inappropriate emergency department utilization
- CN.14- High rates of poor birth outcomes and low birth-weight babies
- CN.15- Insufficient access to services for pregnant women, particularly low income women
- CN.23- Lack of patient navigation, patient and family education and information programs

**How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:**
Currently, a patient navigation program does not exist for obstetrics patients at the Harris Health System. The initiative will be new and will improve access for targeted patients while helping the system to reach capacity for treating obstetrics patients.

On February 15, 2013, the Harris Health System was awarded a cooperative agreement from the Center for Medicare & Medicaid Services for a program entitled Strong Start for Mothers and Newborns. The first period of performance is February 15, 2013 through February 14, 2014 in an
amount not to exceed $355,822. Additional funds for subsequent years through February 14, 2017 will be subject to re-approval each year. Receipt and use of funds is subject to approval by the Harris County Hospital District Board of Managers on March 26th, 2013 and each subsequent award year. The award will provide funding for three Community Health Worker FTEs, two Social Worker FTEs, and one Data Analyst, as well as data collection, patient outreach and recruitment, promotional/educational materials, childcare, and tracking activities, as they relate to Strong Start CenteringPregnancy program participants only. All FTEs and materials will relate specifically to CenteringPregnancy programs at the four targeted Harris Health System prenatal care sites. In order to avoid duplication or replace funding, the OB Navigation Program under DSRIP will not fund Community Health Workers or Social Workers to promote or serve Centering Pregnancy programs at those target sites (Gulfgate Health Center, People’s Health Center, Casa de Amigos Health Center, LBJ OB Clinic). Moreover, the OB Navigation Program under DSRIP will not fund educational/promotional material relating to CenteringPregnancy specifically geared toward those sites. It is our intention that each project will stand alone and will complement, rather than duplicate or supplant the other.

Related Category 3 Outcome Measure(s):
OD-8 Perinatal Outcomes
IT-8.2 Percentage of Low Birth-weight Births
  • The number of babies born weighing <2,500 grams at birth

Reasons/rationale for selecting the outcome measure(s):
Harris County’s low birth weight rate (8.8 %) for the same year is higher than the Healthy People 2020 goal of 7.8% and higher than the 2010 national average of 8.15%. Moreover, the percentage of low birth-weight births at the Harris Health System (LBJ General Hospital and Ben Taub General Hospital combined) for 2011 was 9.9%. Low birth-weight rate is also a Healthy People 2020 objective. IT-8.2 will measure the percentage of low birth-weight births among those patients who have completed the OB Navigation program (received the intervention) by the time of delivery at a Harris Health System hospital. The definition of “program completion” will be determined during the DY2 planning period.

Relationship to other Projects and Other Performing Providers’ Projects in the RHP:
The ability to properly identify and monitor specific patients with chronic conditions or frequent emergency department utilization trends will allow the region to accurately manage the very large patient base. Patient navigation includes a comprehensive list of tasks as well as unique provider types based on the focus of the initiative and will help the focus of cost containment, emergency department utilization, and chronic disease management. The Region 3 Initiative Grid in the addendum allows for a cross reference of all initiatives proposed within this concept.

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

The goal of this project is to utilize community health workers, case managers, social workers, and nurses as a comprehensive patient navigation team that will provide enhanced care coordination, community outreach, social support and culturally competent care to high-risk obstetrics patients throughout their pregnancy. The estimated number of high risk cases at Harris Health on an annual basis is over 2,000. All of those cases will be targeted by this program, with a goal to decrease the percentage of low birth-weight births among patients who complete the program and deliver at Harris Health System. Of those patients who receive patient navigation services, the goal is to decrease the percentage of babies born weighing <2,500 grams at birth to less than DY2 baseline.

---

1Texas Department of State Health Services Center for Health Statistics, (2010)

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>133355104.3.24</th>
<th>IT-8.2</th>
<th>Percentage of Low Birth-Weight Births</th>
<th>133355104</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong></td>
<td></td>
<td>(10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Milestone 1 [P-1]**: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. | **Metric 1 [P-1.1]**: Provide report identifying the following:  
- Targeted patient population characteristics  
- Gaps in services and service needs.  
- How program will identify, triage and manage target population  
- Ideal number of patients targeted for enrollment  
- Number of Patient Navigators needed to be hired  
- Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients  
Goal: Produce a comprehensive report documenting all points above. |  |  |  |  |
| Data Source: Site gap analysis; Program documentation; EHR; State and county data sources | **Year 3**        | (10/1/2013 – 9/30/2014) |        |                                     |           |
| **Milestone 2 [P-2]**: Establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. | **Metric 1 [P-2.1]**: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators.  
Baseline: In DY2, an OB Navigator program did not exist. In addition, a training program, procedures, and continuing education did not exist.  
Goal: Using report from DY2, develop a navigator training program with procedures and continuing education.  
Train team of hired navigators  
Data Source: Training and procedures documentation |  |  |  |  |
| **Milestone 3 [P-X]**: Hire patient navigation team according to plan developed in DY2 | **Milestone 6 [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option.** | **Metric 1 [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period.**  
Baseline: 200 unique pregnant women enrolled (DY3)  
Goal: Increase total number of unique pregnant women enrolled by 600 patients over baseline for a total of 800 patients (DY3-DY4)  
Data Source: Enrollment reports; EHR |  |  |  |
| **Milestone 6 Estimated Incentive Payment**: $1,513,332 | **Milestone 7 [P-X]: Hire patient navigation team according to plan developed in DY2** | **Metric 1 [P-X.1]: Documentation of patient navigation team employment**  
Baseline: Team hired in DY3  
Goal: Expand navigation team to reach enrollment goals  
Data Source: Human Resources |  |  |  |
<p>| <strong>Milestone 7 Estimated Incentive Payment</strong>: $1,400,962 | <strong>Milestone 8 [P-X]: Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. The navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care.</strong> | <strong>Metric 1 [P-X.1]: Collect and report on all the types of patient navigator</strong> |  |  |  |
| <strong>Milestone 10 Estimated Incentive Payment</strong>: 1,740,072 | <strong>Milestone 11 [P-5]: Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. The navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care.</strong> | <strong>Metric 1 [P-5.1]: Collect and report on all the types of patient navigator</strong> |  |  |  |</p>
<table>
<thead>
<tr>
<th>Year 1 (10/1/2012 – 9/30/2013)</th>
<th>Year 2 (10/1/2013 – 9/30/2014)</th>
<th>Year 3 (10/1/2014 – 9/30/2015)</th>
<th>Year 4 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1 [¥-X.1]:</strong> Documentation of patient navigation team employment</td>
<td><strong>Baseline:</strong> 0 hired in DY2</td>
<td><strong>Milestone 7 Estimated Incentive Payment</strong> <em>(maximum amount):</em> $1,513,333</td>
<td><strong>Goal:</strong> Provide report on patient navigation services provided to patients using Harris Health System EDs for Ob care. <strong>Data Source:</strong> Reports documenting services provided to Ob patients.</td>
</tr>
<tr>
<td><strong>Goal:</strong> Hire navigation team consisting of Community Health Workers, Nurses, and Case Managers/Social Workers</td>
<td><strong>Data Source:</strong> Human Resources documentation</td>
<td><strong>Milestone 8 [¥-P]:</strong> Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. The navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care.</td>
<td><strong>Metric 1 [¥-P.1]:</strong> Collect and report on all the types of patient navigator services provided. <strong>Goal:</strong> Provide report on patient navigation services provided to patients using Harris Health System EDs for Ob care. <strong>Data Source:</strong> Reports documenting services provided to Ob patients.</td>
</tr>
<tr>
<td><strong>Metric 1 [¥-10.3]:</strong> Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. <strong>Baseline:</strong> 0 patients served in DY2</td>
<td><strong>Goal:</strong> Enroll 200 unique pregnant women</td>
<td><strong>Milestone 8 Estimated Incentive Payment:</strong> $1,513,332</td>
<td><strong>Milestone 11 Estimated Incentive Payment:</strong> 1,740,072</td>
</tr>
<tr>
<td><strong>Metric 2 [¥-11]:</strong> Increase number of unique patients served by innovative program. <strong>Baseline:</strong> 200 served in DY2</td>
<td><strong>Goal:</strong> Enroll 300 unique pregnant women and special needs patients</td>
<td><strong>Milestone 12 [¥-P]:</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td><strong>Metric 1 [¥-8.1]:</strong> Participate in semi-annual face-to-face meetings or seminars organized by the RHP. <strong>Goal:</strong> Participate in all semi-annual face-to-face meetings or seminars.</td>
</tr>
<tr>
<td><strong>Metric 3 [¥-10]:</strong> Improvements in access to care of patients receiving patient navigation services using innovative project option.</td>
<td><strong>Goal:</strong> Enroll 200 unique pregnant women</td>
<td><strong>Milestone 9 [¥-P]:</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td><strong>Goal:</strong> Participate in all semi-annual face-to-face meetings or seminars.</td>
</tr>
<tr>
<td>133355104.2.4</td>
<td>2.9.1</td>
<td>2.9.1 (A-E)</td>
<td>PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE: OB NAVIGATION PROGRAM</td>
</tr>
<tr>
<td>----------------</td>
<td>--------</td>
<td>------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Harris Health System</strong></td>
</tr>
</tbody>
</table>

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

| 133355104.3.24 | IT-8.2 | Percentage of Low Birth-Weight Births |

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 4 Estimated Incentive Payment (maximum amount):</strong></td>
<td>$1,400,963</td>
<td><strong>Milestone 5 [P-8]:</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td><strong>Data Source:</strong> Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
</tr>
<tr>
<td><strong>Metric 1 [P-8.1]:</strong> Participate in semiannual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $1,400,963</td>
<td><strong>Metric 1 [P-8.1]:</strong> Participate in semiannual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td><strong>Milestone 9 Estimated Incentive Payment:</strong> $1,513,333</td>
</tr>
<tr>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $1,400,963</td>
<td></td>
<td></td>
<td><strong>Milestone 12 Estimated Incentive Payment:</strong> $1,740,072</td>
</tr>
<tr>
<td>Action ID</td>
<td>Category</td>
<td>Outcome Measure(s)</td>
<td>Outcome Description</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
<td>--------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>133355104.2.4</td>
<td>2.9.1</td>
<td>2.9.1 (A-E)</td>
<td>PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE: OB NAVIGATION PROGRAM</td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>133355104.3.24</td>
<td>IT-8.2</td>
<td>Percentage of Low Birth-Weight Births</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $21,023,764
Project Option 2.2.1 - Redesign the outpatient delivery system to coordinate care for patients with chronic diseases: Expansion of Point-Of-Care Services Provided by Clinical Pharmacists

**Project Identification number:** 133355104.2.5/ Pass 3  
**Performing Provider Name/TPI#:** Harris Health/133355104

**Project Summary:**

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

### Volume Statistics - FY2012

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions</td>
<td>35,343</td>
</tr>
<tr>
<td>Births (babies delivered)</td>
<td>6,643</td>
</tr>
<tr>
<td>Emergency visits</td>
<td>173,263</td>
</tr>
<tr>
<td>Outpatient clinic visits</td>
<td>1,054,770</td>
</tr>
</tbody>
</table>

### Patient Payor Mix

- Self-Pay- 62.6%
- Medicaid and CHIP- 23.4%
- Medicare- 8.6%
- Other Funding- 3.6%
- Commercial Insurance- 1.8%

### Patient Demographics

- Hispanic- 57.4%
- African American- 26.3%
- Caucasian- 9.2%
- Asian- 4.8%
- Other- 2.2%
- American Indian- 0.2%

**Intervention(s):**  
This project will expand point-of-care services provided by clinical pharmacists for the chronic management of patients receiving anticoagulation therapy and create an educational website.

**Need for the project:**

Current resources make it difficult to provide timely and efficient post-hospitalization follow up for patients discharged on anticoagulation therapy. While the community standard is for post-hospitalization follow up to occur within 7 days, Harris Health is averaging 20 days for this population.

**Target Population:**

Patient discharged on anticoagulation therapy within the system may benefit from this project (Overall Payor Mix: Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

**Category 1 or 2 expected patient benefits:**

Our goals are to increase the number of care management visits to 7,500 by DY5, realize a 15% increase in the number of refills handled by the refill clinic by DY5, and realize a 75% increase in the number of patients receiving an appointment within 7 days of hospital discharge by DY5.

**Category 3 outcomes:**

IT-1.20: Our goal is to see a 40% increase from baseline of the number of patients seen by clinical pharmacists with at least 2 consecutive INRs at goal by the end of DY5.  
IT-2.3: Our goal is to realize a 15% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications by the end of DY5.
Project Option 2.2.1 - Redesign the outpatient delivery system to coordinate care for patients with chronic diseases: Expansion of Point-Of-Care Services Provided by Clinical Pharmacists

**Project Identification number:** 133355104.2.5/ Pass 3  
**Performing Provider Name/TPI#:** Harris Health/133355104

**Project Description:** Harris Health proposes to expand point-of-care services provided by clinical pharmacists for the chronic management of patients receiving anticoagulation therapy.

Our patient population continues to grow and require anticoagulation therapy monitoring, medication therapy management review to reduce polypharmacy, and provision of medication refills. Current resources have made it difficult to provide timely and efficient post-hospitalization follow up for patients discharged on anticoagulation therapy. While the community standard is for post-hospitalization follow up to occur within 7 days, Harris Health is averaging 20 days for this population. Infrequent or untimely follow up can lead to thrombotic or hemorrhagic complications requiring treatment in the emergency setting or hospitalization. This project will not only allow for additional outpatient capacity but will also create an educational/informational webpage for patients requiring anticoagulation monitoring. The webpage will provide information to educate patients on subjects such as self-management, drug interactions, foods high in vitamin K, emergency procedures and contact numbers.

**Goals and Relationship to Regional Goals:**

**Project Goals:**
- Avoid costly hemorrhagic and thrombotic complications
- Provide appropriate intensive monitoring and management of warfarin therapy
- Reduce adverse drug interactions and contraindications by controlling polypharmacy
- Support timely refills of medications through use of the refill clinics and protocols developed by the primary care providers
- Provide patients the tools they need to take an active role in their healthcare through the use of innovative technology.

This project meets the following regional goals:
- Our program will increase access to specialty care services by allowing us to monitor patients in a timely manner therefore improving patient outcomes and reducing possible complications.
- We will transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model through a coordinated effort involving nursing, pharmacy, physician and other ancillary services in attempts to prevent warfarin related complications. Studies have shown that this collaborative effort leads to improved patient outcomes and patient satisfaction.
- We will develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices via the use of electronic medical records, facilitate regional collaboration and sharing with other institutions providing anticoagulation management services, and engage patients, providers, and other stakeholders in the
planning, implementation, and evaluation processes through constant communication with our medical home team members.

**Challenges:**

- Need for additional pharmacy clinicians and nursing support staff—**Recruit clinical pharmacists and support staff with DSRIP funding**
- Space for daily clinic at multiple community health centers—**Discuss space needs with clinic site leadership and rotate staff to understaffed sites based on space availability**
- Cost of additional Point-Of-Care testing devices and associated supplies—**Include supply needs in DSRIP budget**
- EHR reports that identifies patients suitable for pharmacy management and reports that identify pharmacist-managed patients utilization of emergency center and hospital resources would pose a challenge due to limited FTEs in the Information Technology department and the time to build and run reports—**Meet with IT leadership to develop clinical pharmacy reports**

**5-year Expected Outcome for Provider and Patients:**

- Timely and appropriate follow-up in a pharmacist-run anticoagulation clinic
- Reduction in hospital admissions and emergency room visits secondary to thromboembolic events and bleeding complications
- Increased number of refill requests performed by pharmacists

**Starting Point/Baseline:**

- **Patient visits (FY13- 3/12 to 9/12):** 23,350
- **Unduplicated patients:** approximately 2,300
- **Providers Trained:** 15 Harris Health employed clinical pharmacists; 1 community partner clinical pharmacist
- **Patient Encounters:** Pharmacist-managed clinics have completed 64,459 patient encounters over the 19 month period (March 1, 2011 to September 30, 2012).
- **Clinic Refills over a 3 month period:**
  - Average: 561 refills per month
  - Average MD completed: 238 refills per month
  - Average Pharmacist completed: 323 refills per month

**Rationale:**

Project option 2.2.1 (Redesign the outpatient delivery system to coordinate care for patients with chronic diseases) was chosen to justify the need for the expansion of point-of-care services provided by pharmacists; more specifically for the chronic management of patients receiving anticoagulation therapy. Pharmacist-managed anticoagulation clinics have been shown to improve outcomes in patients on long-term warfarin therapy.\(^1\)\(^-\)\(^7\) Warfarin is the mainstay of oral anticoagulation therapy and its utilization has dramatically increased over recent years.\(^8\)\(^,\)\(^9\) As the indications for oral anticoagulation therapy rise, regular monitoring of patients is pertinent to prevent increasing incidences of warfarin-related complications. This vision directly aligns itself with a Joint Commission’s National Safety Goal of a face-to-face encounter with a healthcare professional for anticoagulation monitoring.
Multiple studies evaluated the clinical implications of high medication burden and identified a heightened risk for medication misadventures such as therapeutic duplication and dosing errors which increase the risk for adverse drug events.\textsuperscript{18, 19} Pharmacists are a cost-effective solution to the concern of medication-related adverse events. Studies indicate that pharmacist-driven Medication Therapy Management (MTM) programs effectively mitigate the potential for medication misadventures translating into the diminution of hospital admission/readmission rates and greater patient and institutional cost-savings.\textsuperscript{20}

Chronic diseases are also a significant cause of morbidity and mortality; especially in patients with poor adherence.\textsuperscript{21-23} Difficulty obtaining medication refills may worsen medication adherence.\textsuperscript{24, 25} The increase in morbidity may in turn cause increased burden on the healthcare system. Studies have demonstrated that multidisciplinary team approaches to care, such as those involving pharmacist-physician collaboration, have shown positive impact in patient care and satisfaction.\textsuperscript{26} Additionally, it has been demonstrated that pharmacist managed refill clinics can increase time efficiency and patient safety.\textsuperscript{27-30}

In recent years there has been an increasing shift in warfarin therapy management from standard care by a physician to dedicated anticoagulation clinic models.\textsuperscript{10} Pharmacist-managed anticoagulation clinics have been established to provide specialized care and manage patients more effectively.\textsuperscript{3} These focused services aim to increase length of time International Normalized Ratios (INR) remain within a therapeutic range as well as reduce thromboembolic and bleeding complications.\textsuperscript{4} Pharmacist-managed anticoagulation clinics provide patients with expert care, frequent monitoring, and education to ensure optimal outcomes and increased patient safety. Education and patient involvement have been shown to increase compliance, leading to improved INR control.\textsuperscript{5} Studies have shown that in comparison to standard care by a physician, specialized pharmacist-managed clinics are associated with improved patient outcomes as a result of more frequent monitoring.\textsuperscript{10, 11-15} In 2003, a clinical pharmacist completed 1,971 visits, but as of fiscal year to date (2013) and 15 pharmacists later, 23,350 visits have been completed.

The Harris Health System program: Expansion of point-of-care services provided by clinical pharmacists is relevant to the RHP population because the project can easily be emulated by our Regional Healthcare Partners as needed.

**Project components:**

- Design and implement care teams that are tailored to the patient’s health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system. - We will design and implement care teams that are tailored to the patient’s healthcare needs through the collaborative efforts of clinical pharmacists, nursing staff, nutritionists, physicians, behavioral services, social services, and health educators to provide exceptional warfarin medication therapy management, reduce polypharmacy and increase number of refill requests performed by pharmacists.
b. **Ensure that patients can access their care teams in person or by phone or Email** - We will ensure that patients have complete access to their personal care teams primarily through face-to-face appointments during scheduled clinic hours as well as through phone and email access via “my health” which a web resource for patients to communicate with physicians, access test results, view clinics visits, and obtain a copy of their medical record.

c. **Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources** - We will increase patient engagement through the use of personal patient education. Clinical pharmacists will educate patients on warfarin side effects, drug interactions, diet restrictions and medication use primarily through face-to-face encounters and telephone encounters after hours.

d. **Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions** - We will implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions through the innovative use of technology. A webpage designed for patients will include health tips that will assist in anticoagulation self-management and ultimately put the patient in control of their personal health. The collaborative efforts of all hospital services will help the patient make life-changing improvements in their health.

e. **Conduct quality improvement for project using methods such as rapid cycle improvement** - Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net population - We will conduct quality improvement for our program by assessing the impact of the point-of-care expansion, reporting the volume of patients seen, refills completed, the number of ED visits and hospitalizations, and adverse drug events, and evaluating any challenges that may be faced over the implementation period.

**Milestones and Metrics:**
- Process Milestones and Metrics: DY2: P-1, P-1.1; P-X, P-X.1; P-2, P-2.1; P-9, P-9.1
- Improvement Milestones and Metrics: I-X1, I-X1.1, I-X2, I-X2.1; I-21, I-21.1

**Community need: The expansion of point-of-care services provided by clinical pharmacists addresses:**
- CN.2- Inadequate access to specialty care
- CN.7- Insufficient access to care coordination practice management and integrated care treatment programs
- CN.11- High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including: Cancer, Diabetes, Obesity, Cardiovascular disease, Asthma, AIDS/HIV
How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

This project significantly enhances our existing delivery system by increasing availability of persons qualified to manage acute and chronic care needs as related to anticoagulation management. This increase in availability not only allows for timely and more frequent patient follow up but also decreases the risk of potential complications which may require management in the acute care setting.

Related Category 3 Outcome Measure(s):

| OD-1 Primary Care and Chronic Disease Management |
| IT-1.20 Other Outcome Improvement Target - Management of International Normalized Ratio (INR) for patients receiving anticoagulation monitoring (standalone measure) |

The pharmacist-run point-of-care anticoagulation services provided by clinical pharmacists at Harris Health will ultimately result in improved patient outcomes. Pharmacist-managed anticoagulation clinics have been established to provide specialized care and manage patients more effectively. These focused services aim to increase length of time INRs remain within a therapeutic range as well as reduce thromboembolic and bleeding complications. Pharmacist-managed anticoagulation clinics provide patients with expert care, frequent monitoring, and education to ensure optimal outcomes and increased patient safety. Education and patient involvement have been shown to increase compliance; leading to improved INR control. We will determine the total number of patients at Harris Health who have INR values for at least 2 consecutive visits by the end of DY2.

With the 6 additional anticoagulation clinics covering a volume of the large pool of patients on warfarin, we can expect that:

- 20% of all patients seen at Harris Health will have at least 2 consecutive INRs at goal by the end of DY3
- 30% of all patients seen at Harris Health will have at least 2 consecutive INRs at goal by the end of DY4
- 40% of all patients seen at Harris Health will have at least 2 consecutive INRs at goal by the end of DY5

OD-2 Potentially Preventable Admissions

IT-2.13 Other Admissions Rate – Hospital Admissions and Emergency Room Visits secondary to warfarin complications (Standalone measure)

There are numerous studies showing that anticoagulation clinics monitoring patients on warfarin have better outcomes as compared to traditional primary physician care. Mehta et al demonstrated that the implementation of an anticoagulation clinic decreased the rate of hemorrhagic and thromboembolic events and achieved better INR control when compared to traditional care by a physician. A study by Cortelazzo et al, showed that an anticoagulation clinic attained superior anticoagulation control and reduced complication rates by 50% to 80% when compared with management provided by primary physicians and cardiologists. Pharmacist-managed anticoagulation clinics have also been shown to decrease warfarin-related hospital admissions and length of stay. This decrease in inpatient admissions, length of stay, and complications suggest that anticoagulation clinics may be a more cost-effective model than...
It is important that we establish a baseline for number of emergency room visits and hospital admissions from warfarin complications (i.e. major and minor bleeding events). We will compare this rate to the calculated rate post-initiation of the 6 pharmacist-run anticoagulation clinics. Based on prior studies and their outcomes, we can expect a:

- 5% reduction from baseline in the number of hospital admissions and emergency room visits secondary to warfarin complications rate at the end of DY3
- 10% reduction from baseline in the number of hospital admissions and emergency room visits secondary to warfarin complications rate at the end of DY4
- 15% reduction from baseline in the number of hospital admissions and emergency room visits secondary to warfarin complications rate at the end of DY5

**Relationship to other Projects and Other Performing Providers’ Projects in the RHP:**
Healthcare costs are significantly increased within a patient base with such aggressive chronic conditions that have gone untreated. The initiatives focused to chronic disease management focus to conditions such as asthma, hypertension, and diabetes and are similar in the approach of managing & proactively treating chronic conditions in order to reduce 30-day readmission rates, inappropriate emergency department utilization, and healthcare costs. The Region 3 Initiative grid allows a cross reference of initiatives associated with chronic disease management.

(Addendum)

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

**Project Valuation:** In recent years there has been an increasing shift in warfarin therapy management from standard care by a physician to dedicated anticoagulation clinic models. Pharmacist-managed anticoagulation clinics provide patients with expert care, frequent monitoring, and education to ensure optimal outcomes and increased patient safety. Education and patient involvement have been shown to increase compliance, leading to improved patient outcomes as a result of more frequent monitoring. This project significantly enhances our existing delivery system by increasing availability of persons qualified to manage acute and chronic care needs as related to anticoagulation management. This increase in availability not only allows for timely and more frequent patient follow up but also decreases the risk of potential complications which may require management in the acute care setting, resulting in a measurable reduction in the number of hospital admissions and emergency room visits secondary to the warfarin complications rate.

**Appendix A: References**
## REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES: EXPANSION OF POINT-OF-CARE SERVICES PROVIDED BY CLINICAL PHARMACISTS

**Harris Health System**

**Related Category: 3**

**Outcome Measure(s):**
- IT-1.20
- IT-2.13

**Management of anticoagulation through use of INR (Stand-alone)**

**Other Admissions Rate (Standalone measure)**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

### Milestone 1: [P-1] Expand the Chronic Care Model to primary care clinics

**Metric 1: [P-1.1]** Increase number of primary care clinics using the Chronic Care model

- Baseline: Identify 6 clinics in which to expand pharmacy services
- Goal: (a) Letter of commitment from nursing and administration at all sites
- (b) Signed collaborative agreement with 2 physicians at each of 3 sites;
- (c) Recruit, hire and train three pharmacists and three patient care technicians (PCTs) to participate in pharmacy managed care.
- Data Source: Documentation of practice management

Milestone 1 Estimated Incentive Payment (maximum amount): $332,998

### Milestone 2: [P-X] Increase the current number of refills handled by pharmacist-run refill clinics

**Metric 1: [P-X.1]** Number of refills handled by the refill clinic

- Baseline: Goal: Establish baseline number of refills handled by pharmacist-run

### Milestone 6: [P-1] Expand the Chronic Care Model to primary care clinics

**Metric 1: [P-1.1]** Increase number of primary care clinics using the Chronic Care model

- Baseline: Identify 6 clinics in which to expand pharmacy services
- Goal: (a) Letter of commitment from nursing and administration at all sites
- (b) Signed collaborative agreement with 2 physicians at additional 3 sites
- (c) Recruit, hire and train three pharmacists and three patient care technicians (PCTs) to participate in pharmacy managed care.
- Data Source: Documentation of practice management

Milestone 5 Estimated Incentive Payment (maximum amount): $383,526

### Milestone 7: [P-2] Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care

**Metric 1: [P-2.1]** Increase percent of staff trained

- Baseline: 15 clinical pharmacists and

### Milestone 10 Estimated Incentive Payment (maximum amount): $996,955

### Milestone 11: [I-X2] Increase the number of patients enrolled in a clinical pharmacist care management

**Metric 1: [I-X2.1]** Number of patients enrolled in a clinical pharmacist care management

- Goal: Increase the number of patient visits to 5000
- Data source: Program enrollment records, EHR

Milestone 11 Estimated Incentive Payment (maximum amount): $996,955

### Milestone 12: [I-X1] Monitor improvement in the number of refills handled by the refill clinic

**Metric 1: [I-X1.1]** Number of refills handled by the refill clinic

- Goal: 10% increase from baseline in the number of refills handled by the refill clinic
- Data Source: Report

Milestone 12 Estimated Incentive Payment (maximum amount): $825,102

### Milestone 13: [I-21]: Improvements in access to care of patients receiving

**Metric 1: [I-21] Improvements in access to care of patients receiving

- Data Source: Program enrollment records, EHR

Milestone 13 Estimated Incentive Payment (maximum amount): $825,102

### Milestone 14: [I-X2] Increase the number of patients enrolled in a clinical pharmacist care management

**Metric 1: [I-X2.1]** Number of patients enrolled in a clinical pharmacist care management

- Goal: Increase the number of patient visits to 7500
- Data source: Program enrollment records, EHR

Milestone 14 Estimated Incentive Payment (maximum amount): $825,102

### Milestone 16: [I-21]: Improvements in access to care of patients receiving

**Metric 1: [I-21]** Improvements in access to care of patients receiving

- Data Source: Program enrollment records, EHR
### Related Category 3

**Outcome Measure(s):**

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Milestone 2 Estimated Incentive Payment (maximum amount): $332,998</th>
</tr>
</thead>
<tbody>
<tr>
<td>133355104.3.25</td>
<td>IT-1.20</td>
<td>Management of anticoagulation through use of INR (Stand-alone)</td>
</tr>
<tr>
<td>133355104.3.26</td>
<td>IT-2.13</td>
<td>Other Admissions Rate (Standalone measure)</td>
</tr>
</tbody>
</table>

#### Year 2

(10/1/2012 – 9/30/2013)

- refill clinics
  - Data Source: Report

**Milestone 2 Estimated Incentive Payment (maximum amount): $332,998**

**Milestone 3:** [P-2] Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care

**Metric 1:** [P-2.1] Increase percent of staff trained
  - Baseline: 15 trained clinical pharmacists; 15 trained PCTs to assist pharmacists
  - Goal: Increase the the number of trained pharmacists and PCTs by 40% from baseline for a total of 21 clinical pharmacists and 21 PCTs
  - Data Source: HR, training program materials

**Milestone 3 Estimated Incentive Payment (maximum amount): $332,998**

**Milestone 4:** [P-9] Develop program to identify and manage chronic care patients needing further clinical intervention

**Metric 1:** [P-9.1] Increase the number of patients identified as needing screening

- 15 PCTs to assist pharmacists (baseline
  - DY2)
  - Goal: Increase the number of pharmacists and PCTs by 40% from baseline for a total of 21 clinical pharmacists and 21 PCTs
  - Data Source: HR, training program materials

**Milestone 6 Estimated Incentive Payment (maximum amount): $583,526**

**Milestone 8:** [I-X1] Monitor improvement in the number of refills handled by the refill clinic

**Metric 1:** [I-X1.1] Number of refills handled by the refill clinic
  - Goal: 5% increase from baseline in the number of refills handled by the refill clinic
  - Data Source: Report

**Milestone 7 Estimated Incentive Payment (maximum amount): $583,527**

**Milestone 9:** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option

**Metric 1:** [I-21.1] Increase percentage of identified population reached
  - Goal: 50% increase in the number of patients receiving an appointment with a clinical pharmacist within 7 days of hospital discharge as compared to baseline.
  - Data Source: Documentation of target population reached, as designated in the project plan.

**Milestone 12 Estimated Incentive Payment (maximum amount): $996,955**

**Milestone 15 Estimated Incentive Payment (maximum amount): $825,102**
<table>
<thead>
<tr>
<th>Related Category</th>
<th>Outcome Measure(s)</th>
<th>Harris Health System</th>
<th>IT-1.20</th>
<th>IT-2.13</th>
<th>Management of anticoagulation through use of INR (Stand-alone)</th>
<th>Other Admissions Rate (Standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>133355104.2.5</td>
<td>133355104.3.25</td>
<td>133355104.3.26</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Identify population of patients needing 7 day follow up for anticoagulation services.</td>
<td>Goal: Management of anticoagulation through use of INR.</td>
<td>Data Source: EHR, patient registry.</td>
<td>Data Source: Documentation of target population reached, as designated in the project plan.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline: TBD</td>
<td>Baseline: TBD</td>
<td>Baseline: TBD</td>
<td>Baseline: TBD</td>
<td>Milestone 4 Estimated Incentive Payment (maximum amount): $332,998</td>
<td>Milestone 8 Estimated Incentive Payment (maximum amount): $583,527</td>
<td>Milestone 10: [I-X] Increase the number of patients enrolled in a clinical pharmacist care management.</td>
</tr>
<tr>
<td>Goal: Identify population of patients needing 7 day follow up for anticoagulation services.</td>
<td>Goal: Management of anticoagulation through use of INR.</td>
<td>Data Source: EHR, patient registry.</td>
<td>Data Source: Documentation of target population reached, as designated in the project plan.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 5: [P-X] Create an educational/informational webpage for patients requiring anticoagulation monitoring.</td>
<td>Milestone 9 Estimated Incentive Payment (maximum amount): $583,527</td>
<td>Milestone 10: [I-X] Increase the number of patients enrolled in a clinical pharmacist care management.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1: Increase the number of webpages available for patients requiring anticoagulation monitoring.</td>
<td>Metric 1: [I-X.1]Number of patients enrolled in a care management with clinical pharmacist.</td>
<td>Goal: Increase the number of patient visits to 2500.</td>
<td>Goal: Increase the number of patient visits to 2500.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline: 0</td>
<td>Baseline: TBD</td>
<td>Data source: Program enrollment records, EHR.</td>
<td>Data source: Program enrollment records, EHR.</td>
<td>Milestone 4 Estimated Incentive Payment (maximum amount): $332,999</td>
<td>Milestone 9 Estimated Incentive Payment (maximum amount): $583,527</td>
<td></td>
</tr>
<tr>
<td>Goal: Increase the number of webpages from 0 to 1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Milestone 10: [I-X] Increase the number of patients enrolled in a clinical pharmacist care management.</td>
<td></td>
</tr>
<tr>
<td>Data source: Harris Health website.</td>
<td></td>
<td>Metric 1: [I-X.1]Number of patients enrolled in a care management with clinical pharmacist.</td>
<td>Goal: Increase the number of patient visits to 2500.</td>
<td>Data source: Program enrollment records, EHR.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment (maximum amount): $332,999</td>
<td>Milestone 9 Estimated Incentive Payment (maximum amount): $583,527</td>
<td>Milestone 10: [I-X] Increase the number of patients enrolled in a clinical pharmacist care management.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount:** $1,664,991  
**Year 3 Estimated Milestone Bundle Amount:** $2,917,633  
**Year 4 Estimated Milestone Bundle Amount:** $2,990,865  
**Year 5 Estimated Milestone Bundle Amount:** $2,475,306

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $10,048,795
Appendix A: References


Project Option 2.6.4 – Implement Evidence-based Health Promotion Program in an Innovative Manner: Integrated Promotion of Fruit and Vegetable Consumption in Primary Care through a Prescription for Healthy Eating Program.

PENDING CMS APPROVAL AS APPROVABLE PROJECT

Unique RHP Project Identification Number: 133355104.2.6/ Pass 3
Performing Provider Name/TPI: Harris Health System/133355104

Project Summary:

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

Volume Statistics - FY2012
<table>
<thead>
<tr>
<th>Hospital admissions</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>35,343</td>
<td>Self-Pay 62.6%</td>
<td>Hispanic 57.4%</td>
</tr>
<tr>
<td>6,643</td>
<td>Medicaid and CHIP 23.4%</td>
<td>African American 26.3%</td>
</tr>
<tr>
<td>173,263</td>
<td>Medicare 8.6%</td>
<td>Caucasian 9.2%</td>
</tr>
<tr>
<td>1,054,770</td>
<td>Other Funding 3.6%</td>
<td>Asian 4.8%</td>
</tr>
</tbody>
</table>

Intervention(s):
This project will develop a program for promoting increased consumption of fruits and vegetables among primary care patients through an integrated approach that includes multi-provider and multi-modal patient education and access to a clinic-based farmer’s market.

Need for the project:
The need for health promotion activities related to fruit and vegetable consumption in Harris County is great. Less than 25% of individuals in the Houston area eat recommended servings of fruits and vegetables. Increase in consumption of fruits and vegetables are both targets for Healthy People 2020.

Target Population:
The target population for these goals includes any patient seen in primary care. (Medicaid and CHIP 23.4% / Self-Pay 62.6%).

Category 1 or 2 expected patient benefits:
Our goal is to increase percentage of target population reached. The DY5 enrollment goal is 1000 patients/month.

Category 3 outcomes:
IT-6.1: Our goal is to increase patient satisfaction scores by 5% above baseline in DY3, 10% in DY4, and 15% in DY5.
Project Option 2.6.4 – Implement Evidence-based Health Promotion Program in an Innovative Manner: Integrated Promotion of Fruit and Vegetable Consumption in Primary Care through a Prescription for Healthy Eating Program.

Unique RHP Project Identification Number: 133355104.2.6/ Pass 3
Performing Provider Name/TPI: Harris Health System/133355104

Project Description:

*Harris Health will develop a program for promoting increased consumption of fruits and vegetables among primary care patients through an integrated approach that includes multi-provider and multi-modal patient education and access to a clinic-based farmer’s market.*

The Integrated Promotion of Fruit and Vegetable Consumption in Primary Care project will bring together primary care providers, health educators, and nutrition specialists to promote increased fruit and vegetable consumption among primary care patients served by Harris Health System. The program will leverage a clinic-based farmer’s market program as the platform from which educational activities will stem.

Harris Health System is the safety-net health system for Harris County, TX. It serves largely ethnic-minority populations (57% Hispanic and 26% African American) from low-income communities. Twenty-eight percent of patients are Medicaid or CHIP, 60% are self pay, and 98% live at or below 200% of the Federal Poverty Level. The health system has 13 community health centers in low-income communities throughout the county. Each is designated as a Medical Home and serves adults and pediatric populations. Approximately half of the clinics are located in United States Department of Agriculture designated food deserts.

Currently a small portion of patients within the system receive healthy eating education or nutrition counseling of any kind. None of the available services focuses specifically on the consumption of fruits and vegetables. This integrated promotion project will involve primary care providers discussing the importance and health benefits of fruit and vegetable consumption with their patients. This will be facilitated by the use of a “healthy eating prescription.” The prescription will allow for the purchasing of discounted produce at a Medical Home-based produce market. In addition to the opportunity to purchase affordable produce, patients will receive education from a designated health educator and dietitian who will reinforce concepts related to the health benefits of the available produce. Likewise, a chef will be present on a regular basis to provide cooking demonstrations using foods from the market so that patients will have greater skill and understanding about how to prepare healthy foods for themselves and their families. Easy to understand recipes will be provided so that patients can practice their learned skills at home. The markets will be present in the Medical Home one half-day weekly so that even without “prescriptions” patients can return and benefit from access to fruits and vegetables, weekly education, and healthy food preparation activities.

Consistent with the Patient Centered Medical Home Model, the multi-component, multi-provider fruit and vegetable promotion team (individual primary care providers, dedicated health educator, nutritionist, and chef) will be located in the Medical Home locations. The team will initially rotate through each of 5 participating clinics. Expansion to 10 sites is expected in year 3 of the project period. Through the prescription program, it is expected that the health promotion team will be able to provide evidence-based, multi-component health promotion education about...
fruit and vegetable consumption to an additional 1000 patients monthly. Quantification of participation will be assessed through redeemed prescriptions.

**Goals and Relationship to Regional Goals:**

The goal of this project is to use a multi-provider, multi-modal approach in the primary care setting to increase fruit and vegetable consumption promotion in high-risk patients. The primary care provider will be the initiator of the health promotion activity and will guide the patient to the other team members who will use the farmers markets as a means to encourage purchasing and consumption of fresh produce and who will provide demonstrations to increase patient taste preferences and self-efficacy around preparation of fresh produce.

**Project Goals:**

- Increase the number of primary care providers promoting the consumption of fruits and vegetables with patients
- Increase the number of patients receiving health promotion to increase fruit and vegetable consumption

This project meets the following regional goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system

The program leverages and builds on existing Harris Health Medical Home farmer’s market infrastructure to meet the need for increased health promotion regarding fruit and vegetable consumption among of high-risk individuals served by the health system.

**Challenges:**

A primary challenge facing the program includes consistent provider promotion of fruit and vegetable consumption. Studies show that physician counseling on lifestyle behavior change has a positive impact on behavior adoption among patients.[1, 2] Providers in Harris Health System recognize the need to counsel patients on healthy lifestyle behavior, but are often hesitant because of the challenges patients face with compliance. This project will leverage the motivating power of the provider-patient relationship. It will equip providers with a tangible tool (prescription) to use in their counseling and will give patients a specific avenue for adoption of the recommended behavior.

An additional challenge involves patient-related barriers to buying fresh produce.[3] Evidence suggests that increasing access to produce in strategic ways can improve healthy eating practices.[4] In this project, the barrier of access is overcome by the presence of markets in the Medical Home. The barrier of cost is addressed by providing a discount on produce cost to patients who present/redeem their prescription at the market.

A third challenge is patient self-efficacy for fruit and vegetable preparation and consumption. Knowledge and skill on how to prepare fresh produce can be a barrier. There is evidence that cooking demonstrations and preparation plans can improve intake.[5, 6] This project will use cooking demonstrations and recipe cards to tackle those barriers.
5-Year Expected Outcome for Provider and Patients:
Harris Health System expects to provide evidence-based fruit and vegetable promotion services to high-risk primary care patients within the health system. Patients can expect to experience consistent, multi-provider integrated health promotion messaging around the health benefits of fruit and vegetable consumption.

Starting Point/Baseline:
Currently, Harris Health System has no evidence-based program to promote fruit and vegetable consumption.

Rationale:
It is recommended by the CDC and other health promoting organizations that individuals consume at least five servings of fruits and vegetables each day. For high risk populations, eight to ten servings are recommended.[7, 8] There is strong evidence from studies like Dietary Approaches to Stop Hypertension that diets high in fruits and vegetables can reduce blood pressure, stroke risk, and weight. It has also been shown to prevent some cancers, and diabetes.[7, 9-11]

The need for health promotion activities related to fruit and vegetable consumption in Harris County is great. Less than 25% of individuals in the Houston area eat recommended servings of fruits and vegetables. By eleventh grade, only 13% of youth eat adequate servings of fruit daily and only 5% eat adequate servings of vegetables.[12] For every serving above two servings of fruits or vegetables eaten daily, risk of ischemic heart disease related mortality decreases by 4%.[13] Increase in consumption of fruits and vegetables are both targets for Healthy People 2020. Specifically, an increase in total vegetable intake in persons two years of age and older is considered a Leading Health Indicator.[14]

Fruit and vegetable promotion interventions are most successful when there are multiple components to the educational initiative.[15] Hands on activities also enhance effectiveness and self-efficacy,[5] and behavioral prescriptions have been show to have positive impact on patient health promotion activities.[16] The project will enhance the medical home model by mitigating silo-based approaches to health promotion; it will integrate and coordinate messages from the primary care provider, health educator, and nutritionist. In addition, the project has the potential to transform the culture and the meaning of the Medical Home itself into one that truly communicates wellness and healthy living to its patients, staff, and the community in which it resides.

The process milestones and accompanying metrics for years 2-3 are consistent with P-3, P-7, and P-X of the RHP Planning Protocol. A multi-provider and multi-component health promotion team will be established to educate, model, and engage patients in the importance of fruits and vegetables for health. A baseline number of patients reached by the program will be established in DY2 and will be the basis for growth going forward. Ongoing plan-do-study-act cycles will allow for review of project data and response to data with new ideas and solutions for improvement.

Improvement outcomes in years 3, 4, and 5 will be based on I-8, increase percentage of target population reached. The establishment of the program will allow an increased number of patients to be reached by focused and coordinated promotion of fruit and vegetable consumption. The goal will be to educate 1000 patients monthly across 10 medical home sites on the health promoting benefits of fruit and vegetable intake.
Project Components:
The core project component will be met as the program is implemented, evaluated, strengthened and expanded into additional clinical sites.

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

Health promotion team members (health educator, dietitian) will meet weekly to review the number of “healthy eating prescriptions” written and redeemed. This will be facilitated by IT reports through the Electronic Health Record and hand-counts of prescriptions collected at the market. Based on utilization, team members will work with health center medical directors to increase provider prescribing patterns and increase patient use of the onsite markets and interactive health promotion activities.

Unique community need identification numbers the project addresses:
- CN.20 - Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Currently there is no coordinated program for the promotion of fruit and vegetable consumption in Harris Health System. The education provided by primary care providers, health educators, and dietitians within the Medical Home is not coordinated or consistent. This initiative will provide a new, focused, and integrated health promotion program for patients served by the health system. It will also significantly enhance the effectiveness and reach of the health center-based farmer’s market program that was piloted in 2011-12.

Related Category 3 Outcome Measures:
OD-6 Patient Satisfaction
IT-6.1: Percent improvement over baseline of patient satisfaction scores

The Category 3 Outcome Measure selected for this project reflects the practice’s ability to support the adoption of healthy behaviors. Evidence suggests that patient satisfaction surveys are a useful tool for assessing and improving quality in practice.[17] Because the primary goal of this project is to increase the number of patients receiving health promotion counseling and self-management guidance around fruit and vegetable consumption, satisfaction regarding the integration of healthy eating promotion into care is an acceptable and established marker of reach and quality. Currently, Harris Health System’s Press-Ganey administered patient satisfaction survey for out-patients includes a domain of questions about the care provider including an item specific to behaviors that improve health.

Relationship to Other Projects and Other Performing Providers in the RHP:
Healthcare treatment cannot focus to only the acute or chronic encounter and properly treat the patient. It is critical that our region focuses to patient education and community education to ensure a proactive and responsive approach to healthcare needs. The education
models represented in the Region 3 RHP plan can be identified in the Initiative Grid (addendum) and all focus to outcome measures such as appropriate utilization, patient satisfaction scores, and stand alone chronic condition scores such as diabetes and asthma.

**Plan for Learning Collaborative:**

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

**Project Valuation:**

The goal of the this project is to develop a program for promoting increased consumption of fruits and vegetables among primary care patients through an integrated approach that includes multi-provider and multi-modal patient education and access to a clinic-based farmer’s market. Providers in Harris Health System recognize the need to counsel patients on healthy lifestyle behavior, but are often hesitant because of the challenges patients face with compliance. This project will leverage the motivating power of the provider-patient relationship. It will equip providers with a tangible tool (prescription) to use in their counseling and will give patients a specific avenue for adoption of the recommended behavior. The goal will be to educate 1,000 patients monthly across 10 medical home sites on the health promoting benefits of fruit and vegetable intake. Evidence from studies like Dietary Approaches to Stop Hypertension have determined that diets high in fruits and vegetables can reduce blood pressure, stroke risk, and weight. It has also been shown to prevent some cancers, and diabetes. Given the high level of chronic disease in the Harris Health patient population, improved diet can have immediate positive impact on the health of our patients, and result in long-term savings in emergency and acute care costs.

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-3]: Implement, document and test an evidence-based innovative project for targeted population</td>
<td><strong>Metric 1</strong> [P-3.1]: Document implementation strategy and testing outcomes</td>
<td>Goal: Implement integrated, coordinated promotion program for fruit and vegetable consumption</td>
<td>Data Source: HR hiring records of dietitian, health educator, chef; health eating prescriptions; program materials</td>
<td><strong>Milestone 4</strong> [P-7]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions</td>
<td><strong>Milestone 6</strong> [I-8]: Increase access to health promotion programs and activities using innovative project option.</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-3.1]: Document implementation strategy and testing outcomes</td>
<td>Goal: Implement integrated, coordinated promotion program for fruit and vegetable consumption</td>
<td>Data Source: HR hiring records of dietitian, health educator, chef; health eating prescriptions; program materials</td>
<td>Goal: Implement integrated, coordinated promotion program for fruit and vegetable consumption</td>
<td>Data Source: HR hiring records of dietitian, health educator, chef; health eating prescriptions; program materials</td>
<td><strong>Metric 1</strong> [P-8.1]: Increase percentage of target population reached</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-X]: Establish baseline number of patients receiving health promotion program (prescriptions for healthy eating)</td>
<td><strong>Metric 1</strong> [P-7.1]: Number of new ideas practices, tools, or solutions tested by each provider</td>
<td>Goal: Weekly improvement in provider and patient engagement in integrated health promotion program</td>
<td>Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week.</td>
<td><strong>Milestone 4</strong> [P-7]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions</td>
<td><strong>Milestone 6</strong> [I-8]: Increase access to health promotion programs and activities using innovative project option.</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-7.1]: Number of new ideas practices, tools, or solutions tested by each provider</td>
<td>Goal: Implement integrated, coordinated promotion program for fruit and vegetable consumption</td>
<td>Data Source: HR hiring records of dietitian, health educator, chef; health eating prescriptions; program materials</td>
<td>Goal: Implement integrated, coordinated promotion program for fruit and vegetable consumption</td>
<td>Data Source: HR hiring records of dietitian, health educator, chef; health eating prescriptions; program materials</td>
<td><strong>Metric 1</strong> [P-8.1]: Increase percentage of target population reached</td>
</tr>
<tr>
<td><strong>Milestone 3</strong> [P-8]: Increase access to health promotion programs and activities using innovative project option.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-8.1]: Increase percentage of target population reached</td>
<td>Goal: Increase by 50% above previous year’s enrollment (Goal 750 patients/month)</td>
<td>Data source: EHR record review for number of prescriptions written and number of prescriptions redeemed at the market</td>
<td><strong>Milestone 5</strong> [I-8]: Increase access to health promotion programs and activities using innovative project option.</td>
<td>Goal: Increase by 30% above previous year’s enrollment (Goal 1000 patients/month)</td>
<td>Data source: EHR record review for number of prescriptions written and number of prescriptions redeemed at the market</td>
</tr>
<tr>
<td><strong>Milestone 4</strong> [P-7]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions</td>
<td>Goal: Weekly improvement in provider and patient engagement in integrated health promotion program</td>
<td>Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week.</td>
<td><strong>Milestone 6</strong> [I-8]: Increase access to health promotion programs and activities using innovative project option.</td>
<td><strong>Milestone 7</strong> [I-8]: Increase access to health promotion programs and activities using innovative project option.</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5</strong> [I-8]: Increase access to health promotion programs and activities using innovative project option.</td>
<td>Goal: Implement integrated, coordinated promotion program for fruit and vegetable consumption</td>
<td>Data Source: HR hiring records of dietitian, health educator, chef; health eating prescriptions; program materials</td>
<td>Goal: Increase by 50% above previous year’s enrollment (Goal 750 patients/month)</td>
<td>Data source: EHR record review for number of prescriptions written and number of prescriptions redeemed at the market</td>
<td></td>
</tr>
</tbody>
</table>

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

- **Year 2** (10/1/2012 – 9/30/2013)
- **Year 3** (10/1/2013 – 9/30/2014)
- **Year 4** (10/1/2014 – 9/30/2015)
- **Year 5** (10/1/2015 – 9/30/2016)

**Milestone 1** [P-3]: Implement, document and test an evidence-based innovative project for targeted population.**

**Metric 1** [P-3.1]: Document implementation strategy and testing outcomes.
- Goal: Implement integrated, coordinated promotion program for fruit and vegetable consumption.
- Data Source: HR hiring records of dietitian, health educator, chef; health eating prescriptions; program materials.

**Milestone 2** [P-X]: Establish baseline number of patients receiving health promotion program (prescriptions for healthy eating).

**Metric 1** [P-X.1]: Number of patients receiving prescriptions during first 6 months of program.
- Goal: Document number of patients receiving prescriptions.
- Data Source: EHR record review for number of prescriptions written.

**Milestone 3** [P-8]: Increase access to health promotion programs and activities using innovative project option.

**Metric 1** [P-8.1]: Increase percentage of target population reached.
- Goal: Increase by 50% above previous year’s enrollment (Goal 750 patients/month).
- Data source: EHR record review for number of prescriptions written and number of prescriptions redeemed at the market.

**Milestone 4** [P-7]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions.

**Metric 1** [P-7.1]: Number of new ideas practices, tools, or solutions tested by each provider.
- Goal: Weekly improvement in provider and patient engagement in integrated health promotion program.
- Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week.

**Milestone 5** [I-8]: Increase access to health promotion programs and activities using innovative project option.

**Metric 1** [I-8.1]: Increase percentage of target population reached.
- Goal: Increase by 30% above previous year’s enrollment (Goal 1000 patients/month).
- Data source: EHR record review for number of prescriptions written and number of prescriptions redeemed at the market.

**Milestone 6** [I-8]: Increase access to health promotion programs and activities using innovative project option.

**Metric 1** [I-8.1]: Increase percentage of target population reached.
- Goal: Increase by 50% above previous year’s enrollment (Goal 750 patients/month).
- Data source: EHR record review for number of prescriptions written and number of prescriptions redeemed at the market.

**Milestone 7** [I-8]: Increase access to health promotion programs and activities using innovative project option.

**Metric 1** [P-8.1]: Increase percentage of target population reached.
- Goal: Increase by 30% above previous year’s enrollment (Goal 1000 patients/month).
- Data source: EHR record review for number of prescriptions written and number of prescriptions redeemed at the market.

**Milestone 6** estimated Incentive Payment: $1,349,980.

**Milestone 7** estimated Incentive Payment: $1,125,884.

**Milestone 1** estimated Incentive Payment: $106,529.

**Milestone 4** estimated Incentive Payment: $657,978.

**Milestone 5** estimated Incentive Payment: $1,349,980.

**Milestone 7** estimated Incentive Payment: $1,125,884.

**Milestone 2** estimated Incentive Payment: $106,529.

**Milestone 3** estimated Incentive Payment: $657,978.

**Milestone 4** estimated Incentive Payment: $1,349,980.

**Milestone 5** estimated Incentive Payment: $1,349,980.

**Milestone 6** estimated Incentive Payment: $657,978.

**Milestone 7** estimated Incentive Payment: $1,125,884. 
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 2 estimated Incentive Payment: $106,528</strong></td>
<td><strong>Milestone 3 [P-7]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions.</strong></td>
<td><strong>Metric 1 [P-7.1]: Number of new ideas, practices, tools, or solutions tested by each provider.</strong> Goal: Weekly improvement in provider and patient engagement in integrated health promotion program. Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week.</td>
<td><strong>Milestone 5 estimated Incentive Payment: $657,977</strong></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $319,585</td>
<td>Year 3 Estimated Milestone Bundle Amount: $1,315,955</td>
<td>Year 4 Estimated Milestone Bundle Amount: $1,349,980</td>
<td>Year 5 Estimated Milestone Bundle Amount: $1,125,884</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5): $4,111,404*
Project Option 2.10.2 - “Other”: Implement other evidence-based project to implement use of palliative care programs: Use of Palliative Care Programs

Unique RHP Project Identification Number: 133355104.2.7/ Pass 3
Provider Name/TPI: Harris Health System / 133355104

Project Summary:

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

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

Intervention(s):
This project will expand our comprehensive palliative care program through the expansion of an integrated, interprofessional house call team of specially trained providers.

Need for the project:
The cost of care for seriously ill and dying patients is frequently greater than the reimbursement for such care due to long length-of-stay and utilization of high-cost beds (ICU), drugs, and procedures, and the fixed payment design of reimbursement.

Target Population:
The target population includes any patients with life-limiting or life-threatening diseases in the hospital clinic and at home. (Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

Category 1 or 2 expected patient benefits:
Our goal is to improved access to Palliative Care Services for residents that did not have access. Our goal is to have seen 1,000 patients by end of DY5.

Category 3 outcomes:
IT-13.1- Increase by 3% in DY4 and 5% in DY5 the percentage of who screened positive for pain and received a clinical assessment of pain within 24 hours of screening.
IT-13.3- Decrease the percentage of patients who died from cancer or other life-limiting illness with more than one emergency room visit in the last days of life by 3% in DY4 and 5% in DY5.
IT-13.4- Decrease the percentage of patients who died from cancer or other life-limiting illness admitted to the ICU in the last 30 days of life by 3% in DY4 and 5% in DY5.
Project Option 2.10.2 - “Other”: Implement other evidence-based project to implement use of palliative care programs: Use of Palliative Care Programs

Unique RHP Project Identification Number: 133355104.2.7/ Pass 3
Provider Name/TPI: Harris Health System / 133355104

Project Description:

*Harris Health System proposes to expand our comprehensive palliative care program.*

Costs at the end of life are greater than any time period during the lifespan due to multiple emergency center visits, unnecessary hospital admissions and long stays in the Intensive Care Unit. The central mission of palliative medicine is to improve or maintain quality of life in patients with life-limiting or life-threatening diseases. Palliative medicine is a recognized medical subspecialty of both the American Board of Medical Specialties and American Osteopathic Association. Palliative medicine involves the control of symptoms associated with chronic disease such as nausea, pain and shortness of breath, as well as management of the symptoms that are part of the dying process. Along with symptom control, palliative medicine teams provide comfort and social and spiritual interventions for patients & their families.

In our current program, we treat patients that have patients with life-limiting or life-threatening diseases in the hospital clinic and at home - in order to avoid unnecessary EC visits, ambulance rides, and hospital and ICU admissions. Numerous published articles have shown palliative care decreases hospital days, increases quality of care, and cuts cost. Since hospice care is not part of the schedule of benefits for the Harris Health System our palliative care team has been making house calls as a strategy to help these high-cost, debilitated, home-limited patients get access to care.

Harris Health System, in partnership with the University of Texas Health Science Center, plans to extend this palliative care program to serve more of the population in need within the region. This project will transform the course of care at the end of life and moves it from the EC and hospital setting to the home environment. This project will also increase access to services for the vulnerable palliative population and reduce costs of care. We propose to provide better, more cost-effective care to the most debilitated, expensive patients served by Harris Health within Harris County through the creation of an integrated, interprofessional team of specially trained providers. Care will be furnished by a physician/nurse practitioner-directed team of health care professionals who are available 24/7 (typically by telephone) to carry out individualized plans of care[9]. Our target population will be patients with life-limiting illness including cancer and heart failure who are at high risk for readmission after discharge home [8]. Therefore, a significant number of our new patient house calls will be “immediately” post-discharge visits[8].

In Demonstration Year 3 we will augment the existing team by adding 3.5 NP FTEs and 1.8 MD FTEs. Each team will care for 500 patients and make 2,500 visits per year once fully active and subscribed. Other professionals, including dedicated pharmacists, therapists, and case managers, will participate in Interdisciplinary Team Meetings held face-to-face or virtually to discuss new and active patients. This interchange will facilitate communication and will contribute to the teaching component. Because the geographic area is so large, a key addition to the team will be a logistics expert who will design processes and schedule visits to minimize traveling distance and maximize efficiency.
Goals and Relationship to Regional Goals:
The goal of this project is to expand our Palliative Care Program with an increase in mid-level practitioners, physicians and social workers to provide palliative care to patients who would otherwise not have access.

Project goals:
- Improve access to palliative care providers which is very limited for this vulnerable population
- Maximize independence
- Reduce unnecessary emergency center visits
- Reduce unnecessary hospital and ICU visits
- Allow patients to receive pain and symptom control resulting in increased patient and caregiver satisfaction

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

Challenges:
The primary challenge will be recruitment of qualified professionals. Data from the 2007 American Hospital Association Annual Survey showed that between 2000 and 2005, the number of hospitals with palliative medicine programs grew by 96% from 632 to 1240[17]. U.S. News and World Report has included palliative medicine as a criterion in its rankings of America’s Best Hospitals since 2003[18]. The development of programs is limited by the dearth of palliative medicine physicians – only 100 per year graduate from US programs [19]. Our affiliation with the training program for Palliative Physicians at the University of Texas Medical School Division of Geriatric and Palliative Medicine will help us address this challenge.

We have a long experience with Palliative Medicine and house calls programs (geriatric, elder abuse and palliative) and already know how to address liability issues, personal safety concerns, time constraints, reimbursement issues, lack of available technology, and logistic issues. We propose a single virtual technology driven coordinating site that will address many of these obstacles including some of the training issues and by linking cost avoidance to the effort in addition to reimbursement, the financial picture is enhanced greatly.

5-Year Expected Outcome for Providers and Patients:
Harris Health intends to improve the end of life care for thousands of residents in our region by increasing the access to pain and symptom control provided by palliative care. We will reduce the usually high costs of caring for these patients by providing the right type of care, in the right setting (hospital, clinic or home). This strategy will provide high satisfaction for patients and their families as well as the providers who serve them. It also allows the emergency center,
hospital and ICUs to be used for appropriate care as pain and symptom control are best delivered outside of these settings.

**Starting Point/Baseline:**

Our current comprehensive palliative house call program began in 2007. The program is currently staffed by 1.0 FTE nurse practitioners (NP) with palliative experience and .2 FTE palliative physician at LBJ Hospital.

In order to create teams to serve more patients, we estimate that the ideal Palliative Care (PC) Team would be comprised of 1.5 physicians and 3 mid-level practitioners such as a nurse practitioner or physician assistants, which would be able to manage 250 palliative patients at any given time with a total of 500 patients being managed in a year. We expect the PC Team patients to survive for approximately six months out of a year. We estimate that we would see each patient for an average of 5 visits per year, completing about 2500 visits per year for each PC Team. The goal in DY3 of the Waiver is to enhance the current PC Team within Harris Health plus half of another team. The goal in DY4 is to increase by 0.5 more PC Teams for a total of 2 PC Teams to cover the region served by the Harris Health System.

**Rationale:**

Palliative medicine programs markedly reduce lengths of stay in hospitals on both wards and ICU settings. According to Morrison et al JAGS supplement April 2007 n>25,000 subjects, palliative care teams saved $1,506 per acute care admission and $5,248 per ICU admission [20]. Palliative care is not hospice, but nonetheless does provide emotional support and relieving symptoms for people in the final six months of a terminal illness. In fact, palliative care can ease illnesses that aggressive treatments often trigger. Expansion of our current program can prevent futile hospital based care where each crisis can cost tens of thousands of dollars [22].

House call based care for home-bound individuals works [1]. Call Doctor Medical Group in San Diego reduced ER visits by 59%[1]. In New York, Mount Sinai Visiting Doctors program reduced hospitalizations by 66% [3]. And the patients are very happy with these programs. At a patient satisfaction rating of 82.7%, the VA House Calls program is the highest satisfaction rating ever received by a VA program[4, 5]. The Mount Sinai program reported 100% of the patients/caregivers believe the program improved their quality of life, 92% reported the quality of care as “outstanding” or “very good”, and 88% reported that the program “definitely” meets their needs[1]. We can have the best of both worlds, better care at lower costs.

**Project Components:**

This project option does not include any required core project components. However, we will increase our capacity to provide palliative care to more individuals, by: a) adding additional palliative care providers, b) adding social workers/case managers, c) adding a logistics expert, and d) forming multidisciplinary care teams. Additionally, we will use performance improvement principles to modify the selection criteria to increase the efficacy of the house calls intervention. We will compare the resource utilization for the three months prior to enrollment in the house calls program to the months after the house calls begin to start to assess the effects of this effort on resource utilization.

**Milestones and Metrics:**

**Process:**

P-5 Milestone: Implement/expand a palliative care program
P-5.1 Metric: Implement comprehensive palliative care program
P-6 Milestone: Increase the number of palliative care consults
P-6.1 Metric: Palliative care consults meet targets established by the program
P-X1 Establish patterns of resource usage including EC and hospital utilization and ICU stays.
P-X1.1 Metric: Evaluate intervention, modify intervention as appropriate, develop policies/procedures, and share lessons learned.

Improvement:
I-11 Milestone: Establish the comfort of dying for patients with terminal illness within their End-of-life stage of care
I-11.2 Metric: Pain assessment (NQF-1637) Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.
I-14 Milestone: Improvements in palliative care services using innovative project option.
I-14.2 Metric: Target population reached through palliative care program: Improved access to PC Services for residents that did not have access.

Unique community need identification number the project addresses:
CN.2–Inadequate access to specialty care (palliative care); CN.6-Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly; CN.8-High rates of inappropriate emergency department utilization; CN.9-High rates of preventable hospital readmissions; and CN.10-High rates of preventable hospital admissions.

How the project represents a new initiative or significantly enhances an existing deliver system reform initiative:
Currently we provide this type of care to less than 350 persons a year (approximately 100 house calls) with 2.0 providers (1 NP and 0.2 MD FTEs). We intend to increase the patient population served to 500/year per team for a total of 1,000 patients served by the end of demonstration year (DY) 5.

Related Category 3 Outcome Measures:
OD- 13 Palliative Care
IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure)
Increase the percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. Exclusion: patients with length of stay <1 day in palliative care who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.
IT-13.3 Proportion with more than one emergency room visit in the last days of life (NQF 0211)- Percentage of patients who died from cancer or other life limiting illness with more than one emergency room visit in the last days of life. (Standalone measure)
IT-13.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213)-Percentage of patients who died from cancer or other life limiting illness admitted to the ICU in the last 30 days of life. (Standalone measure)
Reasons/rationale for selecting the outcome measures:

Provide palliative care services to improve patient outcomes and quality of life. Palliative medicine represents a different model of care, focusing not on cure at any cost but on relief and prevention of suffering. The priority is to support the best possible quality of life for the patient and family, regardless of prognosis. Ideally, the principles of palliative care can be applied as far upstream as diagnosis, in tandem with cure-directed treatment, although it’s still associated in most people’s minds with end-of-life care. There is an economic incentive for hospitals to support palliative care—research shows significant reductions in pharmacy, laboratory, and intensive care costs.

Relationship to other Projects:

There is a proposed house calls program that is similar but targets a population of patients that are home-bound but not necessarily at the end of life, nor have life-limiting disease such as cancer or end stage heart failure. These two projects are complementary and not duplicative since the interventions on house calls will be vastly different.

Relationship to Other Performing Providers’ Projects: The regional need for palliative care is that of upmost priority and is addressed in this initiative. This initiative is unique to Pass 1 initiatives and focuses to outcome measures of pain assessments, treatment preferences, and patients receiving hospice and palliative care. The Region 3 Initiative Grid (addendum) can provide a cross reference to all other initiatives.

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

Project Valuation: The goal of this project is to expand our Palliative Care Program with an increase in mid-level practitioners, physicians and social workers to provide palliative care to patients who would otherwise not have access. This model has been shown to prevent emergency center visits, as well as hospital and ICU admissions. The cost of care for seriously ill and dying patients is frequently greater than the reimbursement for such care due to long length-of-stay and utilization of high-cost beds (ICU), drugs, and procedures, and the fixed payment design of reimbursement. Currently we provide this type of care to less than 350 persons a year (approximately 100 house calls). We intend to increase the patient population served to a total of 1,000 patients by the end of demonstration year (DY) 5. The research available regarding palliative care shows significant reductions in pharmacy, laboratory, and intensive care costs for care coordinated through a palliative program.


### “OTHER”: IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO IMPLEMENT USE OF PALLIATIVE CARE PROGRAMS: USE OF PALLIATIVE CARE PROGRAMS

<table>
<thead>
<tr>
<th>133355104.2.7</th>
<th>2.10.2</th>
<th>N/A</th>
<th>Harris Health System</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s):</strong></td>
<td><strong>Pain assessment</strong></td>
<td>133355104</td>
</tr>
<tr>
<td>133355104.3.28</td>
<td>IT-13.1</td>
<td>Proportion with more than one emergency room visit in the last days of life</td>
<td></td>
</tr>
<tr>
<td>133355104.3.29</td>
<td>IT-13.3</td>
<td>Proportion admitted to the ICU in the last 30 days of life</td>
<td></td>
</tr>
<tr>
<td>133355104.3.30</td>
<td>IT-13.4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Milestone 1 [P-X1]: Planning for expansion of current palliative care program | **Metric 1 [P-X1.1]:** Engage stakeholders, identify resources and potential partnerships, and develop intervention to local context. Baseline/Goal: Appropriate plan and stakeholder engagement for expansion of palliative care program Data Source: Charter for Palliative care program ; Operational Plan | Milestone 1 Estimated Incentive Payment: $1,929,775 |

| Year 2 (10/1/2012 – 9/30/2013) | Milestone 2 [P-6]: Increase the number of palliative care consults Metric 1 [P-6.1]: Palliative Care consults meet targets established by the program Baseline: 350 Goal: 270 additional consults (total of 620 consults) Data Source: EHR, palliative care database | Milestone 2 Estimated Incentive Payment: $808,214 |

| Year 3 (10/1/2013 – 9/30/2014) | Milestone 3 [P-5]: Expand a palliative care program Metric 1 [P-5.1]: Implement comprehensive palliative care program Baseline: 0.2 MD FTEs and 1 NP FTE Goal: Hire additional 1.8 MD FTEs and 3.5 NP FTEs for 1.5 complete teams Data Source: Charter for Palliative care program ; Operational Plan; palliative care team and hiring agreements | Milestone 3 Estimated Incentive Payment: $808,214 |

| Year 4 (10/1/2014 – 9/30/2015) | Milestone 4 [P-5]: Expand a palliative care program Metric 1 [P-5.1]: Implement comprehensive palliative care program Baseline: Currently 2.0 MD FTEs and 4.5 NP FTEs Goal: Hire additional 1 MD FTEs and 1.5 NP FTEs Data Source: Charter for Palliative care program ; Operational Plan; palliative care team and hiring agreements | Milestone 4 Estimated Incentive Payment: $828,450 |

| Year 5 (10/1/2015 – 9/30/2016) | Milestone 5 [I-14]: Improvements using Innovative Program option. Metric 1[I-14.2]: Improved access to PC Services for residents that did not have access. Goal: 650 additional patients above baseline (1000 total patients) Data Source: EHR and PC database Milestone 5 Estimated Incentive Payment: $685,220 | Milestone 5 Estimated Incentive Payment: $828,450 |

| Milestone 10 [I-11]: Establish the comfort of dying patients with terminal illness within their end-of-life stage of care Metric 1[I-11.2]: Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the palliative care initial encounter. Goal: 10% increase Data Source: EHR, palliative care database | Milestone 10 Estimated Incentive Payment: $685,220 | Milestone 10 Estimated Incentive Payment: $685,220 |

<p>| Milestone 11 [P-X]: Establish | | Milestone 11 Estimated Incentive Payment: $685,220 |</p>
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Pain assessment</th>
<th>Proportion with more than one emergency room visit in the last 30 days of life Proportion admitted to the ICU in the last 30 days of life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 4</strong> [P-X1]: Establish patterns of resource usage including EC and hospital utilization and ICU stays. <strong>Metric 1</strong> [P-X1.1]: Evaluate intervention, modify intervention as appropriate, develop policies/procedures, and share lessons learned. <strong>Goal</strong>: Evaluate usage of these resources before and after intervention <strong>Data Source</strong>: Electronic health record <strong>Milestone 4 Estimated Incentive Payment</strong>: $808,213</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5</strong> [P-11]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects <strong>Metric 1</strong>[P-11.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP <strong>Goal</strong>: Participate in learning collaboratives <strong>Goal</strong>: Create customized training for practitioners <strong>Data Source</strong>: Documentation of Regional Healthcare Partnership Plan <strong>Milestone 5 Estimated Incentive Payment</strong>: $685,221</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 7</strong> [I-11]: Establish the comfort of dying patients with terminal illness within their end-of-life stage of care <strong>Metric 1</strong> [I-11.2]: Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the palliative care initial encounter. <strong>Goal</strong>: 5% increase in number of patients screened <strong>Data Source</strong>: EHR, palliative care database <strong>Milestone 7 Estimated Incentive Payment</strong>: 828,451</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 8</strong> [P-11]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects <strong>Metric 1</strong>[P-11.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP <strong>Goal</strong>: Participate in learning collaboratives <strong>Goal</strong>: Participate in learning collaboratives <strong>Data Source</strong>: Documentation of Regional Healthcare Partnership Plan <strong>Milestone 8 Estimated Incentive Payment</strong>: $685,221</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>133355104.3.28 133355104.3.29 133355104.3.30</td>
<td>Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $808,213</td>
<td>Pain assessment Proportion with more than one emergency room visit in the last days of life Proportion admitted to the ICU in the last 30 days of life</td>
</tr>
<tr>
<td>IT-13.1 IT-13.3 IT-13.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harris Health System 133355104</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5):</td>
<td>$1,929,775</td>
<td>$3,232,854</td>
</tr>
<tr>
<td><strong>Region 3</strong></td>
<td><strong>Year 2 Estimated Milestone Bundle Amount:</strong></td>
<td><strong>Year 3 Estimated Milestone Bundle Amount:</strong></td>
</tr>
<tr>
<td><strong>Regional Healthcare Partnership Plan</strong></td>
<td><strong>$1,929,775</strong></td>
<td><strong>$3,232,854</strong></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add milestone bundle amounts over DYs 2-5):</td>
<td><strong>$11,217,312</strong></td>
<td></td>
</tr>
</tbody>
</table>
Matagorda Regional Medical Center
Pass 2
Project Option 2.9.1 Provide navigation services to targeted patients who are at risk of disconnect from institutionalized health care

**Unique RHP Project Identification Number:** 130959304.2.1  
**Performing Provider Name/TPI:** Matagorda Regional Medical Center/ 130959304

**Project Summary:**

Provider:
Matagorda Regional Medical Center is a wholly owned part of Matagorda County Hospital District. The District also operates a primary care clinic for patients qualified for the District’s Medical Assistance Program. The Hospital is a 58 bed acute care facility with a Level III trauma designation.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions- 2594</td>
<td>Self-Pay- 11.5%</td>
<td>Hispanic- 31.1%</td>
</tr>
<tr>
<td>Births - 381</td>
<td>Medicaid and CHIP- 12.8%</td>
<td>African American- 17.2%</td>
</tr>
<tr>
<td>Emergency visits- 18600</td>
<td>Medicare- 50.1%</td>
<td>Caucasian- 50.1%</td>
</tr>
<tr>
<td>Surgeries – 1598</td>
<td>Commercial Insurance- 22.5%</td>
<td>Other- 1.6%</td>
</tr>
<tr>
<td>Outpatient visits -18260</td>
<td>Charity- 3.1%</td>
<td></td>
</tr>
</tbody>
</table>

**Intervention(s):**
The Patient Care Navigation Service will utilize community health workers, case managers, and/or other types of health care professionals to provide enhanced social support and culturally competent care to vulnerable and/or high risk patients; to assist patients in connecting to available primary, specialty, and chronic disease care sites; and to decrease inappropriate visits to the hospital emergency department by steering non-urgent care to available alternatives.

**Need for the project:**
While there has been positive progress in expanding access to community based care, current data reflects that between 40 and 50% of Matagorda Regional Medical Center Emergency Department visits are for diagnosis that could safely be treated in a clinic setting.

**Target Population:**
All patients within the system with may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%), specifically those with no primary care home.

**Category 1 or 2 expected patient benefits:**
Matagorda Regional Medical Center expects to see a decrease in the number of unnecessary visits to the Emergency Department by patients enrolled in the Navigation Program. Our goal is to have 500 frequent ED patients actively enrolled in the Navigation Program by the end of year 5.

**Category 3 outcomes:**
IT-9.2: Our goal is a 25% reduction in unnecessary Emergency Department visits within one year of each patient’s enrollment date in the Patient Care Navigation Service.
Project Option 2.9.1: Provide navigation services to targeted patients who are at risk of disconnect from institutionalized health care: Establish a Patient Care Navigation Program

**Unique RHP Project Identification Number:** 130959304.2.1 / Pass 2  
**Performing Provider Name/TPI:** Matagorda Regional Medical Center/ 130959304

**Project Description:**
A joint planning team was formed with representatives of Matagorda County Hospital District/Matagorda Regional Medical Center, Matagorda Episcopal Health Outreach Program (MEHOP – FQHC), and Palacios Community Medical Center to explore potential models for collaboration. The transformation goals described in the Waiver helped the group crystallize their plans and a new partnership was formed to move the joint planning effort forward. This new organization, Coastal Health Connection, is being incorporated to further the concept of shared infrastructure and shared planning to improve the health of the community. The DSRIP project to establish a Patient Care Navigation Program is an outgrowth of this shared vision of a healthier community.

While there has been positive progress in expanding access to community based care, current data reflects that between 40 and 50% of Matagorda Regional Medical Center Emergency Department visits are for diagnosis that could safely be treated in a clinic setting. During the past 3 years, the community has seen the addition of a well-organized and staffed FQHC (MEHOP), expanded use of physician extenders, and the opening of a private urgent care center and there are active plans in place to continue to improve access to both primary and specialty care throughout the region. The continued inappropriate use of the hospital emergency department as a source of non-emergent care underscores the need for a program or service that will ensure patients receive coordinated, timely, and site-appropriate health care services.

The target zip codes include all of those in Matagorda County and it is expected this program will receive patients from surrounding counties since the patient panels at MEHOP include patients from Matagorda, Wharton, Jackson, and Brazoria counties.

**Target Zip Codes:**
77414, 77404, 77456, 77465, 77457, 77419, 77458, 77415, 77428, 77440, 77480, 77483

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

**Project Goals:**
- Utilize community health workers, case managers, and/or other types of health care professionals as patient navigators;
- Provide enhanced social support and culturally competent care to vulnerable and/or high risk patients;
- Assist patients in connecting to available primary, specialty, and chronic disease care sites;
- Decrease inappropriate visits to the hospital emergency department by steering non-urgent care to available alternatives.

This project meets the following Region 3 goals:
• Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

• Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.

Challenges or Issues Faced:
As a designated health manpower shortage area, access to care is a challenge – particularly access to primary care. The access issue is compounded by the high poverty rate of the County.

The population profile of Matagorda County shows that approximately 50% of the residents live outside the county seat in remote low density areas. Communication about available resources is a challenge.

As a result of these factors, the emergency departments of both hospitals in the county have become the first choice for routine care for many residents of the county. These patterns are long established and often multi-generational. EMTALA, lack of resources, and cultural habits make the emergency department a difficult place from which to steer patients to more appropriate venues for care.

How the Project Addresses Challenges/Issues:
The Patient Care Navigation Program will be a critical component of expanding access to care in the community. There are a number of exciting plans in Matagorda County to expand access and recruit additional providers. Without a mechanism to communicate about the available resources, particularly in more remote areas, patients will not know to seek other venues and continue to rely on the emergency departments. Because the Navigation Program will be custom to the needs of the target populations, the most effective and culturally sensitive method of communication and education can be used.

5-Year Expected Outcome for Provider and Patients:
Matagorda Regional Medical Center expects to see a decrease in the number of unnecessary visits to the Emergency Department by patients enrolled in the Navigation Program. By effectively using community based navigators to “connect” to the target population they are assigned, it is anticipated that through personal communication, education, and advice, patients will more often receive the right care in the right setting. By creating a system of care focused on a coordinated, collaborative approach and early intervention, patients will not be as likely to get “lost” and end up in health crises. The expected outcome is to reduce unnecessary visits to the Emergency Department for the population of patients managed through the Patient Care Navigation Program. Our goal is to have 500 frequent ED patients actively enrolled in the Navigation Program by the end of year 5 with a 25% reduction in unnecessary Emergency Department visits within one year of each patient’s enrollment date.

Starting Point/Baseline:
A Patient Care Navigation Program does not exist for the Matagorda County region and therefore we have no patients in a system of care navigation.

**Rationale/Reasons for selecting the project option:**
The county is served by two acute care hospitals, Matagorda Regional Medical Center and Palacios Community Medical Center. In 2010, the facilities reported 19,368 emergency visits. The hospitals provided more than $16 million in uncompensated care, which accounted for 14.9% of total patient revenue, the second highest percentage in the region.¹ Between 40 and 50% of the visits to the MRMC Emergency Department in 2012² could be considered non-emergent and potentially could be cared for in a less costly venue.

Matagorda County includes the towns of Bay City and Palacios, as well as 15 smaller communities spread throughout the county of more than 1,000 square miles. More than 36,000 people live within the county which has a median household income of $39,874. Nearly 20% of the population lives below the poverty level, and the county has the second highest rate of children living in poverty at 28.4%.³

These factors supported recognition that a personal, almost one-on-one approach was needed to begin re-educating a population that for generations have relied on the emergency department as a primary source of health care. The Patient Care Navigation Program represents that approach.

**Project Components:**
The required core project components include the following:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.

c) Connect patients to primary and preventive care.

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.

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

We will meet these project components with the establishment of the Patient Care Navigation Program as follows:

1. Identification of the target patient base defined by frequent emergency department visits

¹2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospitals Tracking Database
²2012 MCHD Statistical Data Sheet
³U.S. Census Bureau, 2010 Census
2. Development of patient care navigator team including support and administrative staff
   - Staffing plan development including job descriptions: $25,000 - $30,000
   - Recruitment: $20,000
   - Training: $150,000 initial; $25,000/year ongoing
   - Staffing: $600,000

3. Program Offices
   - Space Lease (4 – 5 locations): $120,000/year
   - Furniture/equipment: $50,000
   - Vehicles: $60,000

4. Develop a collaborative model with the primary care community to utilize navigation program
   - Informational material, education, etc: $10,000/year

5. Establish of baseline metrics and then continual measurement for improvement while utilizing process techniques such as PDSA cycles for improvement
   - IT (patient tracking, scheduling, referral systems): $20,000 (one time) + $10,000/year

6. Communication of program information and success in the county, area and region.
   - Educational material, etc.: $10,000

Milestones & Metrics:
The following milestones and metrics have been chosen for the Chronic Care Clinic project based on the core components and the needs of the target population:
   - Process Milestones and Metrics:P-1 (P-1.1); P-2 (P-2.1; 2.2);P-3(P-3.1); P-5 (P-5.1); P-8 (P-8.1); Improvement Milestones and Metrics: I-6(I-6.2); I-8(I-8.1)

Unique community need identification number the project addresses:
The project addresses the following unique community needs as identified in the community needs assessment:
   - CN.1 Access to primary and specialty care
   - CN.2 High utilization of hospital emergency room for non-emergent care
   - CN.3 Percent Uninsured (29.2%) and Percent Poverty (22%) in Matagorda County
   - CN.4 HPSA score of 16

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
As a Hospital District, the main focus of the organization has been on the acute end of the care continuum – primarily hospital and emergency department services. This initiative partners the District with the community through a collaborative with other providers to help patients get the right care in the right setting. This project will also enhance another project goal of creating a system of care for chronic diseases by placing trained patient care navigators in the community to identify opportunities to steer patients into that system.

Related Category 3 Outcome Measure(s):
OD-9 Right Care, Right Setting:
IT-9.2  ED appropriate utilization
• Reduce all ED visits (including ACSC)\(^4\)
• Reduce pediatric Emergency Department visits (CHIPRA Core Measure)\(^5\)
• Reduce Emergency Department visits for target conditions
  o Congestive Heart Failure
  o Diabetes
  o End Stage Renal Disease
  o Cardiovascular Disease /Hypertension
  o Behavioral Health/Substance Abuse
  o Chronic Obstructive Pulmonary Disease
  o Asthma

Reasons/rationale for selecting the outcome measure(s):
Because such a high percentage of the population is uninsured, low income, and under-educated, connecting to the right setting for care can be challenging. The barriers created by these factors include economic and communication. Generations of families have come to rely on the emergency department of hospitals as their sole source of health care.

While there are many factors involved in calculating actual cost savings available if a patient receives care in the most cost effective setting, the charge associated with the lowest acuity visit for a local hospital ED visit is over double that of the same coded visit in a local community clinic.\(^6\) With over 9000 emergency department visits per year in Matagorda County potentially being eligible for care in a different venue, the impact could be significant.

Relationship to Other Projects:
MCHD is also developing a Chronic Disease Specialty Clinic. While the Patient Care Navigation System is not specifically aimed at the chronic disease population, the two projects will overlap with an integrated referral system and have positive impact on appropriate use of the ED.

Relationship to Other Performing Providers’ Projects in the RHP:
The ability to properly identify and monitor specific patients with chronic conditions or frequent emergency department utilization trends will allow the region to accurately manage the very large patient base. Patient navigation includes a comprehensive list of tasks as well as unique provider types based on the focus of the initiative and will help the focus of cost containment, emergency department utilization, and chronic disease management. The Region 3 Initiative Grid in the addendum allows for a cross reference of all initiatives proposed within this concept.

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

\(^4\)http://archive.ahrq.gov/data/safetynet/billappb.htm
\(^6\)MCHD, MEHOP charge master
similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

**Project Valuation:**
Matagorda Regional Medical Center has approximately 20,000 visits to the Emergency Department annually. Records reflect a potential of 40 – 50\(^7\) of the visits could have been treated in another venue. If the Patient Care Navigator Program is successful at reducing unnecessary ED visits by a conservative 10\(^{\%}\), a savings of as much as $2,000,000\(^8\) could be realized by the end of the project period (as compared to a standard physician office visit).

---

\(^7\) MCHD ED Records 2012

\(^8\) Cost of an average ED visit compared to an office visit. *Consumer Health Ratings, 2011*
### PATIENT CARE NAVIGATION PROGRAM

**Matagorda Regional Medical Center**

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>130959304.3.2</th>
<th>IT-9.2</th>
<th>ED Appropriate Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
<td>Milestone 1 [P-1]: Conduct needs assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-1.1]: Provide report identifying targeted patient population. Baseline: No gap assessment has been conducted. Goal: Completion of gap assessment. Data Source: Community Needs Assessment; Gap analysis; EHR. Milestone 1 Estimated Incentive Payment (maximum amount): $81,033</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
<td>Milestone 4 [P-5]: Provide reports on the types of navigation services provided. Metric 1 [P-5.1] Collect and report on all the types of patient navigator services provided. Baseline: Full complement of navigators with initial focus on frequent users of ED Goal: Create a profile of patient needs. Data Source: Program records, ED EHR. Milestone 4 Estimated Incentive Payment: $90,349</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 2 [P-2]: Establish health care navigation program Metric 1 (P-2.1): Select and train navigators Baseline: There are currently no job descriptions or individuals in a navigator position. Goal: Using developed job descriptions, recruit and train initial navigator staff with skill sets to address info from the needs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
<td>Milestone 5 [P-3]: Provide navigation services to targeted patients Metric 1 [P-3.1] Increase in the number or percent of patients enrolled Baseline: Full complement of navigators Goal: Average 15 new enrolled patients per month Data Source: Program records, ED EHR. Milestone 5 Estimated Incentive Payment: $91,660</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 3 [P-8]: Participate in face-to-face learning Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by RHP Milestone 3 Estimated Incentive Payment: $81,032</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
<td>Milestone 7 [I-8]: Reduction in ED use by identified ED frequent users receiving navigation services Metric 1 [I-8.1]: ED visits pre and post navigation services. Baseline: Year 3 reports establishing pre navigation service visits. Goal: Decrease of 25% Data Source: ED and Navigation program records. Milestone 7 Estimated Incentive Payment: $150,902</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 6 [I-6]: Increase the number of PCP referrals Metric 1 [I-22.1]: Percent of patients without a PCP who received education about a primary care provider in the ED. Baseline: Patients without a PCP documented in the medical record. Goal: 50% of targeted patients receive documented education about PCP services. Data Source: ED and Navigator.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td></td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $90,350</td>
<td>analysis. First patients enrolled by beginning of 2nd quarter. Data source: needs assessment, training material, HR documents</td>
<td>program records</td>
<td>Milestone 6 Estimated Incentive Payment: $91,660</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $162,065</td>
<td>Year 3 Estimated Milestone Bundle Amount: $180,699</td>
<td>Year 4 Estimated Milestone Bundle Amount: $183,320</td>
<td>Year 5 Estimated Milestone Bundle Amount: $150,902</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $676,986
Memorial Hermann Hospital
Pass 1
**Project Option:** 2.9.2 Expand COPE/ER Navigation Program

**Performing Provider:** Memorial Hermann Hospital/TPI 137805107

**Unique Project ID:** 137805107.2.1

- **Provider:** Memorial Hermann Hospital (Memorial) is an 860 bed hospital located in Houston, TX and is part of the Houston-Sugarland-Baytown MSA. The MSA population served by Memorial is approximately 6,000,000 people.

- **Intervention(s):** Memorial currently has a COPE and ER Navigation program but is looking to expand them within all Memorial facilities in Region 3. ER Navigation is currently at Memorial Hermann Hospitals Southwest, Northwest, and TMC and will be expanded to Southeast, The Woodlands, Memorial City, Katy, Sugar Land, and Northeast. COPE currently covers all Memorial Hermann Health System acute facilities but with only a 4 person staff. Expansion of COPE staff will increase program penetration, flexibility, and productivity within all 9 facilities.

- **Need for the project:** Emergency Department (ED) use for conditions preventable or treatable with appropriate primary care is associated with inefficient processes and increased risk for poor outcomes. The expansion of COPE and the Navigation will improve access to health care, reduce inappropriate utilization of healthcare facilities and educate individuals about the health and social service resources available to them.

- **Target population:** The target population is all uninsured patients that access the ER for primary care purposes. Future plans are to add Medicaid patients. The expansion of the existing COPE and ER Navigation programs will benefit approximately 15,000 patients over the course of the Waiver, and an estimated 15,000 to 30,000 additional patients annually once the project is fully operational.

- **Category 1 or 2 expected patient benefits:** The expansion of the COPE and ER Navigation programs will establish a baseline of patients reached by Navigators and by DY5 will increase patient contact by 15% over the baseline measured in DY2.

  Based on current information, we estimate the following quantifiable patient benefit:

  - DY3: 11,625 patient encounters
  - DY4: 13,369 patient encounters
  - DY5: 15,113 patient encounters

  We expect that 20% of visits will be to Medicaid patients and 70% to indigent patients

- **Category 3 outcomes:** IT 9.4 – Memorial will collect ED utilization data for patients enrolled in the programs and by DY5, Memorial intends to reduce ED visits in 6 months after enrollment in the programs by 10% under the DY3 baseline.
**Title:** Expand COPE / ER Navigation Program

**Unique RHP Project Identification Number:** 137805107.2.1

**Performing Provider Name/TPI:** Memorial Hermann Hospital (Memorial)/137805107

**Project Description 2.9/2.9.2:** This project will identify uninsured and Medicaid patients utilizing emergency rooms for lower acuity conditions and uninsured patients with a history of repeat ER visits and hospitalizations and, through education, guidance, and follow-up by Certified Community Health Workers (Navigators) and social workers improve access to health care, reduce inappropriate utilization of health care facilities, and educate individuals about the health and social service resources available to them. Through this education and referral to accessible resources, the use of the ER as a primary source of healthcare and/or the escalation of medical conditions resulting from the lack of primary care follow-up that end up in the ER and hospital should be reduced. This project is an expansion of Memorial’s current Community Outreach For Personal Empowerment (COPE) and ER Navigation programs.

Emergency Department (ED) use for conditions preventable or treatable with appropriate primary care is associated with inefficient processes and increased risk for poor outcomes. The Memorial COPE and ER Navigation programs will engage social workers and certified Community Health Workers who have the training, cultural understanding, and linguistic capacity to help the uninsured and at-risk populations, who disproportionately use emergency rooms and other hospital services for healthcare, ‘navigate’ the complex health system, obtain a medical home, schedule appointments, and cope with future healthcare concerns.

Memorial currently has a COPE and ER Navigation program but is looking to expand them within all Memorial facilities in Region 3. ER Navigation is currently at Memorial Hermann Hospitals Southwest, Northwest, and TMC and will be expanded to Southeast, The Woodlands, Memorial City, Katy, Sugar Land, and Northeast. COPE currently covers all Memorial acute facilities but with only a 4 person staff. Expansion of COPE staff will increase program penetration, flexibility, and productivity within all 9 facilities. This project proposes to increase the current four Certified Community Health Workers (Navigators) to 14 navigators and one manager to cover all nine of Memorial Hermann Health System’s ERs and to increase the current four person COPE staff (three social workers and one navigator) by 6 social workers and 2 navigators to increase program penetration, flexibility, and productivity. One Director to manage both programs is also included. This expansion will result in navigation and follow-up of 15,000 additional patients annually.

Both programs require active interventions, tools, and empowering communication to help patients identify, access and obtain community-based services. By using patient navigators to effectively connect uninsured and Medicaid patients with medical homes and other resources and support services, overall primary care ER utilization and costs among target populations will decrease.

This project will identify uninsured and Medicaid patients utilizing emergency rooms for lower acuity conditions and uninsured patients with a history of repeat ER visits and hospitalizations and, through education, guidance, and follow-up by Certified Community Health Workers
Navigators) and social workers improve access to health care, reduce inappropriate utilization of health care facilities, and educate individuals about the health and social service resources available to them. Through this education and referral to accessible resources, the use of the ER as a primary source of healthcare will have documented decreases in ER use within the 9 acute care Memorial Hermann Health System’s Houston area hospitals.

**Goal(s) and relationship to Regional goal(s):**

Project goals:

The goal of this project is to improve access to health care, reduce inappropriate utilization of health care facilities, and to educate individuals about the health and social service resources available to them. Through education and referral to accessible resources, the use of the ER as a primary source of healthcare and/or the escalation of medical conditions resulting from the lack of primary care follow-up that end up in the ER should be reduced. To ensure success, staff will be carefully selected and appropriately trained based on his or her familiarity with the local community’s culture, language, values and vast knowledge about local health care services and community programs. Staff will work one-on-one with individuals and families to identify their needs and link them to community resources that will improve their health, quality of their lives and overall well-being. Much of the work will be done in follow-up, after discharge, ensuring that a clinic appointment was made and was successful; assisting with paperwork required to qualify for Medicaid, CHIP, or county indigent programs; helping individuals and families access resources available in the community such as food, clothing, shelter, employment support, and counseling; and, referring individuals and families to area Benefit Bank of Texas (TBB-TX) counselors to sign up for local, state and federal health care resources and social services such as SNAP/Food Stamps, FAFSA, Medicaid, CHIP, Medicare Extra Help – Prescription and federal taxes. (TBB-TX has recently expanded into Houston.)

This project meets the following Region 3 goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model improving patient satisfaction and health outcomes, reducing unnecessary or duplicative services, and building on accomplishments of our existing health care system.

**Challenges and how addressed:**

Integral to success is the work done post discharge, ensuring that a clinic appointment was made and kept and assisting with paperwork required to qualify for Medicaid, CHIP, or county indigent programs. The population “navigated” is often transient, and communicating with them beyond the short-term is often difficult with phone numbers and residences changing frequently. Memorial will structure this project in order to overcome these challenges, through careful planning, and conducting ongoing quality improvement activities upon its implementation.
5-year expected outcome for provider and patients:

This request proposes to increase the current four Certified Community Health Workers (navigators) to 14 navigators and one manager to cover all nine of Memorial Hermann Health System’s ERs and to increase the current four person COPE staff (three social workers and one navigator) by six social workers and two navigators to increase program penetration, flexibility, and productivity. One Director to manage both programs is also included. This expansion will result in navigation and follow-up of 15,000 additional patients annually.

Starting Point/Baseline: Memorial currently has a COPE and ER Navigation program but is looking to expand them within all Memorial facilities in Region 3. ER Navigation is currently at Memorial Hermann Hospitals Southwest, Northwest, and TMC and will be expanded to Southeast, The Woodlands, Memorial City, Katy, Sugar Land, and Northeast. COPE currently covers all Memorial Hermann Health System acute facilities but with only a 4 person staff. Expansion of COPE staff will increase program penetration, flexibility, and productivity within all 9 facilities.

Rationale:

Traditionally, a hospital’s care of patients ends the instant the patient is discharged. This has resulted in fragmented or overlapping care that is complicated for patients to access and navigate. This complexity often results in no follow-up care, and an inappropriate return to the hospital. This project will offer targeted patient populations assistance in coordinating their care. In addition to helping individual patients, this project will allow all providers across the spectrum of care to utilize their resources more efficiently, delivering care to patients in the most appropriate setting. This will result in lower costs for the delivery system and higher patient satisfaction.

This project uses staff in an effective, cost efficient model to help uninsured and at-risk patients who are high utilizers of health services and/or use the ERs for primary care purposes to: become empowered participants, capable of taking control of their healthcare through the use of appropriate, available, local community resources; to decrease hospital ER visits, observation stays, and inpatient admissions; and to document decreased reliance on the ER as a source for primary and chronic health care. The pilot study of Memorial’s existing ER Navigation Program found that in our target population of uninsured and publicly insured patients, mean ER visits significantly declined in the 12-month post-intervention period, compared to the 12-month pre-intervention period. After conducting several sub-analyses based on frequency of pre-intervention PCR ED use, we found this result to be robust for both low and high utilizers of ED services. The pilot study of Memorial’s existing COPE Program found that in our target population of uninsured patients reductions in ER/Observation/Inpatient utilization resulted in a savings of $5,328 per patient. The savings associated with both programs far outweighs the costs to implement them. Additionally, both programs’ findings are consistent with previous research demonstrating that case management effectively reduced the total number of visits for high ED utilizers (Okin et al., 2000; Pope, Fernandes, Bouthillette, & Etherington, 2000).
Project Components:
N/A

Unique community need identification number the project addresses:

- CN.8: High rates of inappropriate emergency department utilization
- CN.9: High rates of preventable hospital readmissions
- CN.10: High rates of preventable hospital admissions

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

Memorial currently completes limited post-discharge support for a small subset of its patient population. This program would allow Memorial to expand the level of post-discharge support by dedicating personnel and resources, offering enhanced support such as transportation, and offering navigation services to all patients with certain targeted conditions.

Related Category 3 Outcome Measure(s): OD-9: Right Care, Right Setting; IT 9.4 Other Outcome Improvement Target—ED Appropriate Utilization.

Data Collection Methodology: Memorial resources are compared pre/post-navigation intervention at like pre/post intervals; i.e. pre/post 6 months, pre/post 1 year, etc.
- Pre data: # of ER visits 6 months pre-navigation intervention.
- Post data: # of ER visits 6 months post-navigation intervention.
  - This data is similarly compared at 12 months, 18 months, and 24 months.
  - This data is similarly compared for a sub-population identified as frequent flyers: those with 1+ pre-navigation visits, 3+ pre-navigation visits, and 5+ pre-navigation visits.
- For COPE patients, Inpatient and Observation activity is presented in pre/post data in addition to ER at 6 months, 12 months, 18 months, and 24 months.
- (Note: pre/post data activity of navigated patients is available for all Memorial Hermann Health System patient activity but not for services rendered at non Memorial Hermann Health System facilities.)

Reasons/rationale for selecting the outcome measure(s):
If patients are educated on the resources available to assist them, the use of the ER as a primary source of healthcare and/or the escalation of medical conditions resulting from the lack of primary care follow-up that end up in the ER should be reduced.

Relationship to other Projects: This project is part of Memorial’s larger plans to expand and develop primary care and specialty care services, while improving access to care and implementing delivery improvements targeted to specific populations (in this case, uninsured and Medicaid patients facing access barriers). It works closely with the greater Houston Safety Net Community.

Relationship to Other Performing Providers’ Projects in the RHP: Memorial Hermann Health System reflects the vision of other Performing Providers’ in the RHP by increasing
individual and family access to healthcare, improving the quality of healthcare, reducing costly ED usage for primary care treatable issues, educating the community on alternative healthcare resources available to them, the importance of a medical home, and reducing overall healthcare costs. It works closely with the greater Houston Safety Net Community.

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

**Project Valuation:**

**Approach for valuing project:** The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

**Rationale/justification for valuation:** The implementation of a patient care navigation program will significantly improve access to both primary and specialty care for targeted patient populations, foster more efficient use of the community’s healthcare resources, and ultimately result in reduction of healthcare costs; Memorial took these factors into account when considering the appropriate incentive payment value for this project.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>137805107.3.12</td>
<td>IT-9.4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COPE (COMMUNITY OUTREACH FOR PERSONAL EMPOWERMENT) AND ER NAVIGATION**

**Memorial Hermann Hospital**

**OTHER OUTCOME IMPROVEMENT TARGET—ED APPROPRIATE UTILIZATION**

**Milestone 1** [P-1]: Conduct a Needs Assessment to identify patient population(s) to be targeted with the Patient Navigator Program.

**Metric** [P-1.1]: Provide report identifying targeted patient population characteristics; how the program will identify, triage, and manage patient population; and number of required navigators and social workers to be hired.

**Data Source**: Program documentation, EHR, and needs assessment survey.

**Goal**: To target populations and improve the efficiency of the project.

**Milestone Estimated Incentive Payment**: $1,258,318.66

**Milestone 2** [P-X]: Establish baseline for number of target population reached by patient navigators.

**Metric**: Establish baseline for future years.

**Data Source**: Submission of documentation demonstrating study of baseline numbers.

**Milestone 4** [P-2]: Establish/expand a health care navigation program which will provide support to patient populations most at risk of receiving disconnected and fragmented care, including a program to train navigators, develop procedures and establish continuing navigator education.

**Metric** [P-2.3]: Frequency of contact with care managers/navigators for high-risk patients.

**Data Source**: Patient navigation program materials and database, EHR.

**Baseline/Goal**: Increase patient contact by 5% over baseline measured in DY2.

**Milestone Estimated Incentive Payment**: $1,029,568.50

**Milestone 8** [P-2]: Establish/expand a health care navigation program which will provide support to patient populations most at risk of receiving disconnected and fragmented care, including a program to train navigators, develop procedures and establish continuing navigator education.

**Metric** [P-2.3]: Frequency of contact with care managers/navigators for high-risk patients.

**Data Source**: Patient navigation program materials and database, EHR.

**Baseline/Goal**: Increase patient contact by 10% over baseline measured in DY2.

**Milestone Estimated Incentive Payment**: $1,032,561.50

**Milestone 12** [P-2]: Establish/expand a health care navigation program which will provide support to patient populations most at risk of receiving disconnected and fragmented care, including a program to train navigators, develop procedures and establish continuing navigator education.

**Metric** [P-2.3]: Frequency of contact with care managers/navigators for high-risk patients.

**Data Source**: Patient navigation program materials and database, EHR.

**Baseline/Goal**: Increase patient contact by 15% over baseline measured in DY2.

**Milestone Estimated Incentive Payment**: $852,985.75

**Milestone 13 CQI P-3**: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects.

**Metric CQI P-3.1**: Number of meetings, conference calls or webinars organized by the RHP that the provider participated in.

**Milestone Estimated Incentive Payment**: $852,985.75
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>137805107.3.12</th>
<th>IT-9.4</th>
<th>OTHER OUTCOME IMPROVEMENT TARGET—ED APPROPRIATE UTILIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong></td>
<td>(10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal</strong>: To determine baseline for measure of project improvement in future years.</td>
<td>Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, and emails.</td>
<td>Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, and emails.</td>
<td>Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, and emails.</td>
</tr>
<tr>
<td><strong>Milestone 3 CQI P-3</strong>: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects.</td>
<td>Goal: To achieve continuous quality improvement. This is a required component of this project required in the approved DSRIP menu.</td>
<td>Goal: To achieve continuous quality improvement. This is a required component of this project required in the approved DSRIP menu.</td>
<td>Goal: To achieve continuous quality improvement. This is a required component of this project required in the approved DSRIP menu.</td>
</tr>
<tr>
<td><strong>Metric CQI P-3.1</strong>: Number of meetings, conference calls or webinars organized by the RHP that the provider participated in.</td>
<td>Milestone Estimated Incentive Payment: $1,029,568.50</td>
<td>Milestone Estimated Incentive Payment: $1,032,561.50</td>
<td>Milestone Estimated Incentive Payment: $852,985.75</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Meeting Agendas, sign-in sheets, conference calls, presentations, and emails.</td>
<td><strong>Goal</strong>: To maintain and improve the quality of services provided by the project.</td>
<td><strong>Milestone 6 [P-3]</strong>: Provide care management/navigation services to targeted patients.</td>
<td><strong>Milestone 10 [P-3]</strong>: Provide care management/navigation services to targeted patients.</td>
</tr>
<tr>
<td><strong>Goal</strong>: To maintain and improve the quality of services provided by the project.</td>
<td><strong>Metric 1 [P-3.1]</strong>: Increase in the number or percent of targeted patients enrolled in the program.</td>
<td><strong>Metric 1 [P-3.1]</strong>: Increase in the number or percent of targeted patients enrolled in the program.</td>
<td><strong>Metric 1 [P-3.1]</strong>: Increase in the number or percent of targeted patients enrolled in the program.</td>
</tr>
<tr>
<td><strong>Baseline/Goal</strong>: Increase number of patients enrolled in program by 5%.</td>
<td>Numerator: Number of targeted patients enrolled in the program.</td>
<td>Numerator: Number of targeted patients enrolled in the program.</td>
<td>Numerator: Number of targeted patients enrolled in the program.</td>
</tr>
<tr>
<td><strong>Denominator</strong>: Total number of targeted patients identified.</td>
<td>Baseline/Goal: Increase number of patients enrolled in program by 10%.</td>
<td>Denominator: Total number of targeted patients identified.</td>
<td>Denominator: Total number of targeted patients identified.</td>
</tr>
<tr>
<td><strong>Milestone Estimated Incentive Payment</strong>: $1,258,318.66</td>
<td><strong>Milestone 14 [P-3]</strong>: Provide care management/navigation services to targeted patients.</td>
<td><strong>Baseline/Goal</strong>: Increase number of patients enrolled in program by 15%.</td>
<td><strong>Baseline/Goal</strong>: Increase number of patients enrolled in program by 15%.</td>
</tr>
<tr>
<td><strong>Year 3</strong></td>
<td>(10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong></td>
<td>(10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong></td>
<td>(10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>Other Outcome Improvement Target—ED Appropriate Utilization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IT-9.4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2** (10/1/2012 – 9/30/2013)

Data Source: Enrollment reports.

Milestone Estimated Incentive Payment: $1,029,568.50

**Milestone 7** I-6: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services.

**Metric 1** I-6.4: Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment.

**Numerator:** Number of patients without a documented PCP that receive an appointment with a PCP as a function of the care navigation program.

**Denominator:** Number of patients without a documented PCP using the care navigation program.

**Goal:** 5% increase over baseline.

**Data Source:** Performing Provider administrative data on patient encounters and scheduling records from Patient

**Year 3** (10/1/2013 – 9/30/2014)

Data Source: Enrollment reports.

Milestone Estimated Incentive Payment: $1,032,561.50

**Milestone 11** I-6: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services.

**Metric 1** I-6.4: Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment.

**Numerator:** Number of patients without a documented PCP that receive an appointment with a PCP as a function of the care navigation program.

**Denominator:** Number of patients without a documented PCP using the care navigation program.

**Goal:** 10% increase over baseline.

**Data Source:** Performing Provider administrative data on patient encounters and scheduling records from Patient

**Year 4** (10/1/2014 – 9/30/2015)

Data Source: Enrollment reports.

Milestone Estimated Incentive Payment: $852,985.75

**Milestone 15** I-6: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services.

**Metric 1** I-6.4: Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment.

**Numerator:** Number of patients without a documented PCP that receive an appointment with a PCP as a function of the care navigation program.

**Denominator:** Number of patients without a documented PCP using the care navigation program.

**Goal:** 15% increase over baseline.

**Data Source:** Performing Provider administrative data on patient encounters and scheduling records from Patient

**Year 5** (10/1/2015 – 9/30/2016)

Data Source: Enrollment reports.

Milestone Estimated Incentive Payment: $852,985.75

**Milestone 15** I-6: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services.

**Metric 1** I-6.4: Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment.

**Numerator:** Number of patients without a documented PCP that receive an appointment with a PCP as a function of the care navigation program.

**Denominator:** Number of patients without a documented PCP using the care navigation program.

**Goal:** 15% increase over baseline.

**Data Source:** Performing Provider administrative data on patient encounters and scheduling records from Patient
**COPE (COMMUNITY OUTREACH FOR PERSONAL EMPOWERMENT) AND ER NAVIGATION**

**Memorial Hermann Hospital**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>137805107.3.12</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 2 I-6.3</strong>: Percent of patients without a primary care provider who were referred to a primary care provider in the ED</td>
<td><strong>Numerator</strong>: Number of ED patients without a documented PCP that receive a referral to a PCP.</td>
<td><strong>Denominator</strong>: ED patients without a documented PCP.</td>
<td><strong>Goal</strong>: 5% increase over baseline.</td>
<td><strong>Data Source</strong>: Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program in web-based tool.</td>
<td><strong>Data Source</strong>: Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program in web-based tool.</td>
</tr>
<tr>
<td><strong>Numerator</strong>: Number of ED patients without a documented PCP that receive a referral to a PCP.</td>
<td><strong>Denominator</strong>: ED patients without a documented PCP.</td>
<td><strong>Goal</strong>: 5% increase over baseline.</td>
<td><strong>Data Source</strong>: Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program in web-based tool.</td>
<td><strong>(We currently estimate that there will be 13,000 patient encounters in DY4)</strong></td>
<td><strong>(We currently estimate that there will be 15,000 patient encounters in DY4)</strong></td>
</tr>
<tr>
<td><strong>Milestone Estimated Incentive Payment</strong>: $1,029,568.50</td>
<td><strong>Milestone Estimated Incentive Payment</strong>: $1,032,561.50</td>
<td><strong>Milestone Estimated Incentive Payment</strong>: $1,032,561.50</td>
<td><strong>Milestone Estimated Incentive Payment</strong>: $1,052,985.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Milestone Bundle Amount</strong>: $3,774,956</td>
<td><strong>Year 3 Estimated Milestone Bundle Amount</strong>: $4,118,274</td>
<td><strong>Year 4 Estimated Milestone Bundle Amount</strong>: $4,130,246</td>
<td><strong>Year 5 Estimated Milestone Bundle Amount</strong>: $3,411,943</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $15,435,419**
**Project Option:** 2.10.1 Implement a Palliative Care Program  
**Performing Provider:** Memorial Hermann Hospital/TPI 137805107  
**Unique Project ID:** 137805107.2.2

- **Provider:** Memorial Hermann Hospital (Memorial) is an 860 bed hospital located in Houston, TX and is part of the Houston-Sugarland-Baytown MSA. The MSA population served by Memorial is approximately 6,000,000 people.

- **Intervention(s):** Memorial will implement a comprehensive palliative care program that will engage patients with life threatening, acute or chronic conditions. The program will also educate health care professionals so they can better advise their patients who need end-of-life care outside an acute care setting.

- **Need for the project:** Currently, the region only has light adoption of palliative care and there are many hospitals that have no access to palliative care, and there is virtually no access to outpatient palliative care. A palliative care program is needed to improve the quality of life for patients and their families and could be more widely embraced by dying patients and caregivers if they were better educated about this service and made aware of its benefits.

- **Target population:** There are two types of people the program will target 1) health care professionals and caregivers that will be educated on the services and benefits of palliative care, and 2) patients that would normally seek end-of-life care in an acute care setting so they may be transitioned to home care, hospice or a skilled nursing facility. Memorial expects to be managing a population of approximately 140,000 patients in the next 12 months, and will be enrolling all eligible patients from that population into the palliative care program that meet clinical criteria. In addition, in years two and three of the program, after the infrastructure is implemented, the palliative care program will be enrolling all eligible identified Medicaid/uninsured populations that meet clinical eligibility criteria.

- **Category 1 or 2 expected patient benefits:** Patients in need of palliative care will benefit from having options to their end-of-life care other than seeking out an emergency room or an acute care setting.  
  Over the course of the project, Memorial expects approximately 7075 patients as a result of this project as follows:
  
  1500 patients in DY 3
  2275 patients in DY 4
  3300 patients in DY 5

  Memorial expects approximately 21%-24% of these patients will be Medicaid or indigent.

- **Category 3 outcomes:** IT 13.3 Proportion with more than one ER visit in the last days of life – 10% improvement over baseline. The palliative care program will accelerate the
growth and increase the availability of palliative care in the region providing an alternative to ER utilization for patients in the last days of life.
Project Option- 2.10.1 Implement a Palliative Care Program to address patients with end-of-life decisions and care needs: Use of Palliative Care Programs

Unique RHP Project Identification Number: 137805107.2.2
Performing Provider Name/TPI: Memorial Hermann Hospital (Memorial)/137805107

Project Description: Implement a comprehensive palliative care program in cooperation with Memorial’s physician group, MHMD, that will engage patients through the Primary Care physician network and enroll patients in the palliative care program through physician offices rather than waiting for an acute hospitalization to occur. This project will target patients with life threatening acute or chronic conditions.

Palliative care is a newer medical specialty focusing on improving life and providing comfort to people of all ages with serious, chronic, and life-threatening illnesses. These diseases may include cancer, congestive heart failure, kidney failure, chronic obstructive pulmonary disease, AIDS, and Alzheimer’s, and others. This focus also reduces readmissions, health care costs and improves quality of life for families and those providing the care and support to these patients.

Goal(s) and relationship to Regional goal(s):

Project goals:
Provide palliative care services to improve patient outcomes and quality of life. Palliative medicine represents a different model of care, focusing not on care at any cost but on relief and prevention of suffering. Here the priority is supporting the best possible quality of life for the patient and family, regardless of prognosis. Ideally, the principles of palliative care can be applied as far upstream as initial diagnosis of a serious illness, and may be used in tandem with cure-directed treatment. Program goals include: improved pain and symptom control, improved patient satisfaction, reductions in hospital length of stay, reduced cost of care by transitioning appropriate acute care patients to the program, and decreased inpatient mortality.

Memorial should be a national leader in providing palliative and hospice care. A well-coordinated approach to providing Palliative Care access at each acute care hospital will greatly improve the cost of care provided under healthcare reform, improve satisfaction scores, increase referrals to hospice when appropriate, help to meet regulatory mandates and improve philanthropy. Memorial has a reputation for quality medicine and caring, and it makes sense to expand Memorial’s mission by providing palliative and hospice services.

This project meets the following Region 3 goals:
This project addresses the RHP’s goal to “[t]ransform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.”

Challenges and how addressed: Challenges to this project include: upstream application of palliative care principles; application of a model of care with which many patients and families may be unfamiliar; selecting reliable program partners in forming the palliative care program;
integrating the program into the current care model; integrating providers who may be resistant to changing their practice methodology; and improving patient satisfaction who are suffering from chronic or terminal illnesses.

Memorial will address the challenge of selecting a reliable program partner by thoroughly analyzing potential community collaborators. Memorial will integrate the program into the current care model by identifying and accepting patients to participate in the supportive and end of care program. Memorial will also integrate the program by embracing evidence-based care transitions and interventions designed to improve quality of life and satisfaction for patients with chronic and terminal conditions. Furthermore, extensive education will increase physician understanding and will increase patient satisfaction. The palliative care program will address patient satisfaction by developing tailored education, training and standard communication protocols to ensure patients are provided informed choice on the topic of advanced care wishes. Patient advocacy, patient preferences, and patient choice will be a top priority and documentation of patient preference will be recorded within the individual’s health record.

**5-year expected outcome for provider and patients:**
Providers will have better access to and a better understanding of palliative care treatment. Patients will have better satisfaction and quality of life during end of life care.

**Starting Point/Baseline:** Currently, the Houston area only has light adoption of palliative care as a solution to patient satisfaction and outcomes in patients who have serious or life-threatening acute or chronic illnesses. There are many hospitals that have no access to palliative care, and there is virtually no access to outpatient palliative care services. Because the majority of the milestones and metrics for this project are associated with educating clinical staff on the appropriate use of palliative care, the baseline will need to be assessed by surveying providers in ICU and other specialty areas to care to gauge their current education level.

Over the past 7 years, Memorial has taken several isolated steps to address palliative and end of life care. More recently, the MHMD Clinical Ethics and Palliative Care Committee established a multidisciplinary work group, consisting of physicians, nurses, CMOs, administrators, a chaplain, a six sigma black belt, and the chair of geriatrics and palliative medicine at UTHSC Houston. This group was charged with evaluating the value of expanding palliative medicine services across Memorial Hermann Health System. After careful review, the work group recommended that Memorial take a clear and coordinated path to expand Palliative Care across Memorial Hermann Health System. Increasing these services is the right thing to do and the smart thing to do.

**Rationale:**
While end-of-life care was once associated almost exclusively with terminal cancer, today people receive end-of-life care for a number of other conditions, such as congestive heart failure, other circulatory conditions, COPD, and dementia. Further, some experts have suggested that palliative and hospice care could be more widely embraced by dying patients and caregivers if they were better educated about this service and made aware of its benefits. However, these experts say that overly rigid quality standards and poorly aligned reimbursement incentives discourage appropriate end-of-life care and foster incentives to provide inappropriate restorative...
care and technologically intensive treatments. Experts also note that hospitals, nursing homes, and home health agencies need stronger incentives to provide better access to palliative care and care coordination either directly, themselves, or by contract with outside suppliers. It seems clear that improving care coordination near the end of life can improve care for patients with chronic conditions; however, palliative care should also allow children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness.

A palliative care program is needed in an acute care setting in order to improve the quality of life for patients and their families facing the issues associated with life-threatening illness through the prevention and relief of suffering by means of early identification and assessment and treatment of issues including physical, psychosocial and spiritual. Today’s healthcare environment has seen an increase in the number of older patients with co-morbidities which results in much sicker patients in the hospital setting. This increase in patient acuity can greatly benefit from palliative care.

This palliative end of life care program will provide value by decreasing inpatient costs, increasing patient and family satisfaction, and improving quality through symptom management and comfort care at end of life. Palliative care consultation services will optimize symptom management, facilitate end-of-life conversations, and assist with timely transitions between sites of care.

**Project components:**
This project will meet the following required core components:
(a) Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program;
- Memorial will develop a palliative care business case and conduct planning activities as part of the negotiation and contracting process
(b) Transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility;
- Memorial will transition palliative care patients from its facilities to into home care
(c) Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time
- will implement a patient/family experience survey as part of this project, to be administered to the population of patients served by the project, and their families.
(d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.
- Memorial will conduct quality improvement activities as part of the hospice program established under this project.

**Unique community need identification number the project addresses:**
- CN.2 - Inadequate access to specialty care
- CN.6 - Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly
- CN.8-High rates of inappropriate emergency department utilization

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

There is only a small palliative care presence relative to the population of Region 3. This project would be a significant improvement to the healthcare delivery system by addressing that deficiency. In the Houston market, three non-Memorial Hermann Health System hospitals, Methodist, St. Luke’s and MD Anderson, have palliative care consultation teams. In contrast to Memorial Hermann Health System, none of these systems has palliative care teams at hospitals outside the Texas Medical Center. MD Anderson has a fellowship program in Palliative Medicine which graduates only 5 physicians annually. Dr. Carmel Dyer, professor and chair of the UTHSC division of geriatrics and palliative medicine, strongly supports the creation of a fellowship program in palliative medicine in affiliation with Memorial. Such a program would allow a greater breadth of training in not only palliative care of cancer patients but in all facets of adult and pediatric palliative care. Post-acute care services are available through Memorial home health’s Palliative Life program and hospice. These services are not currently available across Memorial Hermann Health System’s entire service area. The department of geriatrics and palliative medicine at UTHSC has one palliative medicine clinic providing out-patient services at its Bellaire location. As expected in a specialty newly recognized by the American Board of Medical Specialties, there is a limited supply of trained physicians and nurses. None of the local nursing schools have post-graduate programs in palliative nursing and only MD Anderson has a program for physicians.

**Related Category 3 Outcome Measure(s):** OD-13: Palliative Care; IT-13.3 Proportion with more than one ER visit in the last days of life.

**Reasons/rationale for selecting the outcome measure(s):**
The ER is not the appropriate site of treatment for end of life care. This project will, therefore, reduce the reliance on ERs for patients who are terminally ill.

**Relationship to other Projects:** This project is part of Memorial’s larger plans to expand and develop primary care and specialty care services, while improving access to care and implementing delivery improvements targeted to specific populations (in this case, terminally ill patients). This project reinforces Project 2.9, Establish/Expand a Patient Navigation System. The palliative care program will redirect terminally and chronically ill patients out of acute care and into the program. This compliments several goals of Project 2.9—decreasing health care costs and increasing high quality patient-centered care.

This project is also related to Project 2.2, Expand Chronic Care Models. Both projects aim to increase efficiency through improved management of chronic conditions. Additionally, these projects are focused on improving care while also specific patients out of acute care centers.

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

Project Valuation:

Approach for valuing project: The valuation of each Memorial project takes into account the transformational impact of the project, the population served (both number of people and complexity of patient needs), the alignment with community needs, the magnitude of costs avoided or reduced, the degree of collaboration involved, and the sustainability of the project.

Rationale/justification for valuation: In valuing this project, Memorial took into account the extent to which a palliative and end of life care program would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

The expansion of palliative care will help address a substantial need in the community for patient-centered care for chronically ill and terminally ill patients. It also advances the Waiver goal of improving outcomes while curbing the risk of healthcare costs.

How Palliative Care Improves Clinical Quality:

The time demand on care providers frequently impairs adequate communication, and many providers are not well equipped to manage complex patient/family dynamics. Inadequate time for communication with patients and families fosters unrealistic expectations that lead to wasteful use of resources in an era of impending healthcare reform. Most patients with cancer have unrealistically optimistic expectations regarding their prognosis and response to therapy. For example, one recent study reported that most of the patients with lung cancer surveyed expected to live for more than 2 years even though the average length of survival is about 8 months. Palliative Care consultation helps the oncologist provide truly informed consent by sharing anticipated response rates, reviewing treatment burden, discussing transitional care to hospice, and allowing patients and families to make informed decisions to maintain hope. The SUPPORT study found, in patients preferring DNR, less than 50% of their physicians were aware of their wishes. This led to 46% of DNR orders being written within 2 days of death. Intervention by Palliative Care increases the rate of completion of DNR orders. In addition, half of the SUPPORT study patients had moderate to severe pain over 50% of the time in their last 3 days of life. For patients with complex symptoms or multiple co-morbidities, establishing an effective medication regimen can challenge physicians. Particularly in the area of pain management, the mixture and dosage of drugs required is outside the experience of many physicians. Palliative Medicine physicians are well versed in how best to manage complex pain issues. Early palliative care interventions frequently improve a patient’s ability to complete curative regimens and even extend life. In 2010, the New England Journal of Medicine reported
results of a study of patients with metastatic non-small cell lung cancer. These patients are known to have a significant symptom burden and to receive aggressive end of life care. Patients were randomly assigned to receive early palliative care integrated with standard oncologic care or standard oncologic care alone. Those who received early palliative interventions reported better quality of life, improved mood, better documentation of resuscitation preferences and less aggressive end of life care. Even though fewer patients in the early palliative group received aggressive end of life care, median survival among the early palliative group was 23% longer.

Currently, patients with two or more chronic conditions account for 95% of Medicare spending. These encompass the oldest of the old whose cohort is among the fastest growing. It is estimated that by 2030 the number of patients over 85 will double. This tidal wave of older patients with multiple medical problems will be coupled with a less than 20% penetration of the US population with advance directives. Palliative Care teams increase the rate of completion of advance directives. According to a report from the Medicare Payment Advisory Commission (MedPAC), about a quarter of the total Medicare budget is spent on services for beneficiaries in their last year of life, 40% of that in the last 30 days. Palliative Care decreases unrealistic expectations that lead to wasteful use of resources in an era of impending healthcare reform. Patients facing serious or life-threatening illnesses account for a disproportionately large share of Medicaid spending. Data from 2004–07 at four New York State hospitals was used in one study to determine the effect on hospital costs of palliative care team consultations for patients enrolled in Medicaid. On average, patients who received palliative care consultations incurred $6,900 less in hospital costs during a given admission than a matched group of patients who received usual care. These reductions included $4,098 in hospital costs per admission for patients discharged alive, and $7,563 for patients who died in the hospital. Consistent with the goals of a majority of patients and their families, palliative care recipients spent less time in intensive care, were less likely to die in intensive care units, and were more likely to receive hospice referrals than the matched usual care patients.

The Affordable Care Act will undoubtedly lead to bundled payments to both hospitals and physicians. We anticipate that palliative care services will bridge the gap in communication that many times leads to unnecessary, expensive, and incongruent care.

Training and education of physicians and nursing staff is imperative to the success of palliative care programs. The Center to Advance Palliative Care (CAPC) provides site consultative and educational services. We believe this investment to ensure uniformity and consistency across the MH system is key to the success of the program. As the program grows, patient and staff satisfaction with end of life care will improve. We anticipate philanthropic support for education, training, and staff services.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 [P-X]:</strong></td>
<td>Establish baselines for P-2, P-3, I-9 to be used to determine the success of project in future years.</td>
<td><strong>Milestone 3 [P-2]:</strong> Educate primary care specialties (e.g., family medicine, Internal Medicine, Pediatrics, Geriatrics, and other IM subspecialties) in providing palliative care.</td>
<td><strong>Milestone 5 [P-2]:</strong> Educate primary care specialties (e.g., family medicine, Internal Medicine, Pediatrics, Geriatrics, and other IM subspecialties) in providing palliative care.</td>
<td><strong>Milestone 7 [P-2]:</strong> Educate primary care specialties (e.g., family medicine, Internal Medicine, Pediatrics, Geriatrics, and other IM subspecialties) in providing palliative care.</td>
<td><strong>Milestone 9 [P-2]:</strong> Educate primary care specialties (e.g., family medicine, Internal Medicine, Pediatrics, Geriatrics, and other IM subspecialties) in providing palliative care.</td>
</tr>
<tr>
<td>Metric:</td>
<td><strong>Metric [P-2.1]:</strong> Primary care specialties training and education in palliative care.</td>
<td><strong>Metric [P-2.1]:</strong> Primary care specialties training and education in palliative care.</td>
<td><strong>Metric [P-2.1]:</strong> Primary care specialties training and education in palliative care.</td>
<td><strong>Metric [P-2.1]:</strong> Primary care specialties training and education in palliative care.</td>
<td><strong>Metric [P-2.1]:</strong> Primary care specialties training and education in palliative care.</td>
</tr>
<tr>
<td>Goal: To establish baseline for future years.</td>
<td>Baseline/Goal: Educate 10% of the provider workforce that is involved in ICU, Medical, Internal Medicine, and other specialty fields with patients who are hospice appropriate.</td>
<td>Baseline/Goal: Educate 10% of the provider workforce that is involved in ICU, Medical, Internal Medicine, and other specialty fields with patients who are hospice appropriate.</td>
<td>Baseline/Goal: Educate 10% of the provider workforce that is involved in ICU, Medical, Internal Medicine, and other specialty fields with patients who are hospice appropriate.</td>
<td>Baseline/Goal: Educate 10% of the provider workforce that is involved in ICU, Medical, Internal Medicine, and other specialty fields with patients who are hospice appropriate.</td>
<td>Baseline/Goal: Educate 10% of the provider workforce that is involved in ICU, Medical, Internal Medicine, and other specialty fields with patients who are hospice appropriate.</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Submission of documentation demonstrating study of baseline measures.</td>
<td>Data Source: Training and Education Materials, dates of trainings and attendance</td>
<td>Data Source: Training and Education Materials, dates of trainings and attendance</td>
<td>Data Source: Training and Education Materials, dates of trainings and attendance</td>
<td>Data Source: Training and Education Materials, dates of trainings and attendance</td>
<td>Data Source: Training and Education Materials, dates of trainings and attendance</td>
</tr>
<tr>
<td><strong>Milestone 2 [P-8]:</strong> Document the conditions for which palliative care is consulted.</td>
<td><strong>Milestone 4 [CQI P-1]:</strong> Participate in interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.</td>
<td><strong>Milestone 6 [CQI P-1]:</strong> Participate in interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.</td>
<td><strong>Milestone 8 [CQI P-1]:</strong> Participate in interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.</td>
<td><strong>Milestone 10 [CQI P-1]:</strong> Participate in interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.</td>
<td><strong>Milestone 12 [CQI P-1]:</strong> Participate in interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.</td>
</tr>
<tr>
<td>Metric [P-8.1]: Breadth of conditions for which palliative care is utilized.</td>
<td><strong>Metric [P-1.1]:</strong> Number meetings, conference calls, or webinars organized</td>
<td><strong>Metric [P-1.1]:</strong> Number meetings, conference calls, or webinars organized</td>
<td><strong>Metric [P-1.1]:</strong> Number meetings, conference calls, or webinars organized</td>
<td><strong>Metric [P-1.1]:</strong> Number meetings, conference calls, or webinars organized</td>
<td><strong>Metric [P-1.1]:</strong> Number meetings, conference calls, or webinars organized</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Number of chronic conditions for which the palliative care patients are consulted</td>
<td><strong>Denominator:</strong> Total number of patients admitted with chronic conditions</td>
<td><strong>Denominator:</strong> Total number of patients admitted with chronic conditions</td>
<td><strong>Denominator:</strong> Total number of patients admitted with chronic conditions</td>
<td><strong>Denominator:</strong> Total number of patients admitted with chronic conditions</td>
<td><strong>Denominator:</strong> Total number of patients admitted with chronic conditions</td>
</tr>
</tbody>
</table>

**Proportion with More than One ER Visit in the Last Days of Life**
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>137805107.3.13</th>
<th>IT-13.3</th>
<th>Proportion with More than One ER Visit in the Last Days of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td>conditions or MCC</td>
</tr>
<tr>
<td>Baseline/Goal: Establish baseline for above criteria</td>
<td></td>
<td></td>
<td>conference calls, or webinars organized by the RHP that the provider participated in.</td>
</tr>
<tr>
<td>Data Source: EHR; palliative care database/ case management database</td>
<td></td>
<td></td>
<td>Baseline/Goal: n/a</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Data Source: Documentation of phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td>by the RHP that the provider participated in.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Baseline/Goal: n/a</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Data Source: Documentation of phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
<td>Milestone 7 [I-9]: Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Metric 1 [I-9.1]: Transitions accomplished.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Numerator: Number of palliative care discharges to hospice, homecare, or SNF</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Denominator: Total number of palliative care discharges</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Baseline/Goal: 20% increase over DY2 baseline to increase hospice appropriate consults and discharges.</td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td>Metric 1 [I-9.1]: Transitions accomplished.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Numerator: Number of palliative care discharges to hospice, homecare, or SNF</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Denominator: Total number of palliative care discharges</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Baseline/Goal: 20% increase over DY2 baseline to increase hospice appropriate consults and discharges.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Approximately 3300 patients)</td>
</tr>
<tr>
<td>Gibraltar</td>
<td></td>
<td></td>
<td>Data Source: EHR; data warehouse; palliative care database.</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Proportion with More than One ER Visit in the Last Days of Life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>137805107.3.13</td>
<td>IT-13.3</td>
<td>Proportion with More than One ER Visit in the Last Days of Life</td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $3,699,957</td>
<td>Year 3 Estimated Milestone Bundle Amount: $4,036,454</td>
<td>Year 4 Estimated Milestone Bundle Amount: $4,048,188</td>
<td>Year 5 Estimated Milestone Bundle Amount: $3,344,156</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $15,128,755</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Memorial Hermann Northwest Hospital
Pass 1
**Project Option:** 2.2.5 Psych Response Team – Case Management  
**Performing Provider:** Memorial Hermann Hospital System/TPI 020834001  
**Unique Project ID:** 020834001.2.1

- **Provider:** Memorial Hermann Hospital System (Memorial Hermann) is a 1,164 bed hospital system consisting of 8 campuses in the Houston-Sugarland-Baytown MSA. The system serves a population of approximately 6,000,000 people.

- **Intervention(s):** The project will provide a 24/7 liaison to act as an adjunct to the Psych Response Team and provide case management of post-discharge behavioral health patients. Case management will identify individuals whose chronic mental illness predicts they will likely have repeat visits to the ER and connect them with case management services for follow-up after discharge.

- **Need for the project:** Follow-up with behavioral health patients after discharge is a service not currently provided. The patients struggle with non-compliance in prescribed health maintenance activities post-discharge. This project will give behavioral health patients access to necessary follow-up information, as well as a resource for questions regarding their diagnosis and treatment.

- **Target population:** The target population is all behavioral patients whose conditions are chronic and require individual case management to ensure their treatment is given in a suitable setting and manner. It is estimated that 20% of people in Harris County suffer from behavioral health issues of which 25% are uninsured and another 18% or 701,559 are covered by Medicaid. Of the 18% of residents covered by Medicaid, approximately 8% have received some type behavioral health treatment. Memorial Hermann anticipates this project will address the needs of 500 to 2000 patients annually.

- **Category 1 or 2 expected patient benefits:** Most of the target population are frequent patients of the emergency room, which is not an appropriate setting for chronic behavioral health care. This project will provide the patients with more individualized treatment for their conditions and provide them with options for seeking treatment in more appropriate settings.

Over the course of the project, Memorial Hermann expects approximately 2050 patient visits as a result of this project as follows:

- 250 patient visits in DY 3
- 600 patient visits in DY 4
- 1200 patient visits in DY 5

Memorial Hermann expects approximately 35% of these patients to be on Medicaid and approximately 65% of these patients to be indigent.

- **Category 3 outcomes:** IT 3.8 – The case management project will result in more intensive case management of post-discharge behavioral health patients. The Behavioral
Health/Substance Abuse (BH/SA) 30-day readmission rate should see a 10% reduction in BH/SA readmissions by DY5.

**Title: Psych Response Team - Case Management**

**Unique RHP Project Identification Number:** 020834001.2.1

**Performing Provider Name/TPI:** Memorial Hermann Hospital System (Memorial Hermann)/020834001

**Project Description 2.2/2.2.5:**

Provide a 24/7 liaison to act as an adjunct to the Psych Response Team to provide more intensive case management of "post-discharge" behavioral health patients to reduce recidivism and increase compliance with follow-up. Emergent Psych Patient Volumes increased 25% in all Memorial Hermann Health System Acute Care hospitals from FY 2007 – 2012; which averaged an annual volume increase of almost 5% per year (Total Response Team Volume for FY 2012: 6,924 Patient Encounters). Reasons for increases: the ER is the only available primary care site for an increasing number of indigent patients; current provider appointment scheduled but symptoms too acute to wait for services; missed appointments, patients have insurance but do not know how to access/navigate Behavioral Care.

**Goal(s) and relationship to Regional goal(s):**

Project Goal:

Reduce readmission rates and increase compliance with follow-up after discharge through case management of behavioral health patients.

This project meets the following Region 3 goals:

This project addresses the RHP’s goal to “[i]ncrease access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.”

**Challenges and how addressed:**

Individuals with chronic mental health conditions struggle with non-compliance in prescribed health maintenance activities, such as medicine management, follow-up, and Medicaid enrollment activities. Memorial Hermann also anticipates difficulties in recruiting competent behavioral health staff to provide 24/7 services. To address these challenges, Memorial Hermann will engage in an aggressive recruitment campaign and deliver services in a manner that places the patient at the center of care decisions wherever possible, which has shown to improve the behavior of non-compliant patients.
5-year expected outcome for provider and patients:

After the project has been fully implemented, Memorial Hermann expects that there will be a significant decrease in potentially preventable readmissions.

Starting Point/Baseline: Memorial Hermann does not currently have case management component to its psychiatric response team. The volume of patients served by this project will come from the existing psychiatric response team and additional referrals.

Rationale:

This project will give behavioral health patients access to necessary follow up information, as well as a resource for questions regarding their diagnosis and treatment. This source of information will prevent unnecessary ED visits, and will achieve better compliance with follow-up care.

Project components:
There are no required components for this project option.

Unique community need identification number the project addresses:
- CN.5 – Inadequate access to care for veterans and active military, particularly mental health and substance abuse services.
- CN.3 -- Inadequate access to behavioral healthcare.

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

The Psych Response Team Program does not have a case management component in its current state. The primary charge of the Psych Response Team is to evaluate the behavioral health patients in Memorial Hermann Health System Acute Care Hospitals (EDs or medical units) and refer the patient to the appropriate level of care necessary. Follow-up with the patient after discharge is a not service currently provided. The thirteen year history of the Psych Response Team has revealed that patients with psychiatric illnesses are higher utilizes of ED services than the general population. This is in-part due to poor follow-up after discharge. The new initiative, the Case Management adjunct to the Psych Response Team, would identify individuals whose chronic mental illness will likely predict they will have repeat visits to EDs for on-going services and connect with case management services for follow-up after discharge. These services would provide consistent support to ensure compliance with follow-up recommendations and proactively engage the patient in aftercare services in order to prevent reliance on the most expensive level of care in the community, hospital EDs.

Related Category 3 Outcome Measure(s): OD-3: Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs); IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate.
Reasons/rationale for selecting the outcome measure(s):
Coordination of behavioral healthcare has a direct and proven impact on the reduction of potentially preventable readmissions, for both behavioral care issues as well as comorbidities. Therefore, this Category 3 outcome measure in an appropriate measure for the success of this project.

Relationship to other Projects: This project is part of Memorial Hermann’s larger plans to enhance healthcare delivery with a model of care management that allows staff to work with at-risk patients with chronic behavioral health disorders. Due to the high incidence of non-compliance with treatment recommendation in the targeted population, these patients are high utilizers of ERs. This project would seek to educate and empower consumers to access and navigate a healthcare delivery system through the use of appropriate, available, local community resources; to decrease hospital ER visits and to document decreased reliance on emergency rooms as a resource for chronic behavioral healthcare.

Relationship to Other Performing Providers’ Projects in the RHP: TBD

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

Project Valuation:

Approach for valuing project: The valuation of Memorial Hermann’s projects uses a method which ranks the importance of each project based on several key factors. First, Memorial Hermann considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, Memorial Hermann considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, Memorial Hermann reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

Rationale/justification for valuation: This particular project improves both the quality of healthcare and the efficiency of the delivery system—both important goals of the Waiver. In
addition, this project promotes the delivery of behavioral health, which is particularly needed in Region 3. Specifically, this project manages chronic mental illness by identifying individuals who are at risk of unnecessary and repeated visits to the ER and connecting them to case management services. These services will provide post-discharge support to targeted patients and increase their compliance with follow-up care. The result is a reduction in unnecessary ER visits, better access to care, and more cost-efficient care for mental illness. These outcomes justify the incentive value of this project.
<p>| Milestone 1: | Establish baseline for number of staff for community based behavioral patients enrolled in a self-management program, number of patients identified as needing screening tests, preventative tests, or other clinical services, and number of patients with self-management goals. | Establish baseline for future years. Data Source: Submission of documentation demonstrating study of baseline numbers. Goal: To determine baseline for measure of project improvement in future years. |
| Milestone 2: | Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects. | CQI: P-1 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects. Metric: CQI: P-1.1 Number of meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, email. |
| Milestone 3: | Develop program to identify and manage chronic care patients needing further clinical intervention. | Milestone 7: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects. Metric: CQI: P-1.1 Number of meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, email. |
| Milestone 4: | Develop program to identify and manage chronic care patients needing further clinical intervention. | CQI: P-1 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects. Metric: CQI: P-1.1 Number of meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, email. |
| Milestone 5: | Increase the number of patients identified as needing screening tests, preventative tests, or other clinical services. | Increase the number of patients identified as needing screening tests, preventative tests, or other clinical services. Metric: CQI: P-1.1 Number of meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, email. |
| Milestone 6: | Increase the number of patients enrolled in a self-management program. | Increase the number of patients enrolled in a self-management program. Metric: CQI: P-1.1 Number of meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, email. |
| Milestone 7: | Develop program to identify and manage chronic care patients needing further clinical intervention. | Develop program to identify and manage chronic care patients needing further clinical intervention. Metric: CQI: P-1.1 Number of meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, email. |
| Milestone 8: | Increase the number of patients identified as needing screening tests, preventative tests, or other clinical services. | Increase the number of patients identified as needing screening tests, preventative tests, or other clinical services. Metric: CQI: P-1.1 Number of meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, email. |
| Milestone 9: | Develop program to identify and manage chronic care patients needing further clinical intervention. | Develop program to identify and manage chronic care patients needing further clinical intervention. Metric: CQI: P-1.1 Number of meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, email. |
| Milestone 10: | Improvements in access to care for patients receiving chronic care management services. | Improvements in access to care for patients receiving chronic care management services. Metric: CQI: P-1.1 Number of meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, email. |
| Milestone 11: | Increase the number of patients identified as needing screening tests, preventative tests, or other clinical services. | Increase the number of patients identified as needing screening tests, preventative tests, or other clinical services. Metric: CQI: P-1.1 Number of meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, email. |</p>
<table>
<thead>
<tr>
<th>020834001.2.1</th>
<th>2.2.5</th>
<th>N/A</th>
<th>DEVELOP CARE MANAGEMENT FUNCTIONS THAT INTEGRATE THE PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS: PSYCH RESPONSE TEAM - CASE MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Memorial Hermann Hospital System</strong></td>
<td>020834001</td>
<td></td>
<td><strong>Related Category 3 Outcome Measure(s):</strong> 020834001.3.7, IT-3.8 <strong>Behavioral Health/Substance Abuse (BH/SA) 30-Day Readmission Rate</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Year 2</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Baseline/Goal: 5% increase over DY2 baseline.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Data Source P-11.1: EHR, patient registry, class enrollment and attendance records.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Milestone 6</strong> [I-21]: Improvements in access to care for patients receiving chronic care management services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Metric 1 [I-21.1]: Increase percentage of target population reached.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Baseline/Goal: 5% increase over baseline established in DY2.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Data Source: Documentation of target population reached, as designated in the project plan.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Approximately 250 patient visits)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $3,998,361</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $16,348,900</td>
</tr>
</tbody>
</table>
**Project Option:** 2.9.2 MHMD Care Management  
**Performing Provider:** Memorial Hermann Hospital System/TPI 020834001  
**Unique Project ID:** 020834001.2.2

- **Provider:** Memorial Hermann Hospital System (Memorial Hermann) is a 1,164 bed hospital system consisting of 4 campuses in the Houston-Sugarland-Baytown MSA. The system serves a population of approximately 6,000,000 people.

- **Intervention(s):** Memorial Hermann will implement a comprehensive care management infrastructure for populations attributed to the MHMD Clinical Integrated Network of Patient Centered Medical Home (PCMH) practices. Care Managers will be assigned to these practices to identify frequent ED users and connect patients to primary and preventative care. The project will also involve training hundreds of physicians in the new style of managing care. These physicians will be able to transfer the skills and institutional knowledge they gain from this project to all of their patients.

- **Need for the project:** The region suffers from a higher-than-average at risk rate for diseases when compared to the statewide average. Through this project the coordination of care for patients will improve quality of life and healthcare cost effectiveness with decreased ER visits, decreased hospital length of stay and decreased end-of-life hospital admissions.

- **Target population:** The target population is attributed PCMH patients in Harris, Montgomery and Fort Bend Counties. Memorial Hermann anticipates the number of patients managed by this program will be about 160,000 by April of 2013. We anticipate the number of managed Medicaid/uninsured populations under this program to increase significantly over the next 3 years.

- **Category 1 or 2 expected patient benefits:** MHMD Case Management will provide support to patient populations who are at most risk of receiving disconnected or fragmented care and will increase patient contact by 15% over baseline measured in DY2.

Over the course of the project, Memorial Hermann expects approximately 560,700 patients as a result of this project as follows:

178,000 patients in DY 3  
186,900 patients in DY 4  
195,800 patients in DY 5

Memorial Hermann expects approximately 5% of these patients to be Medicaid and indigent patients. However, if the project proves to be efficient at reducing costs and creating better outcomes, Memorial Hermann expects to expand the project to its entire patient population which is approximately 25% Medicaid and indigent.

- **Category 3 outcomes:** IT 6.1 – Percent Improvement over baseline of patient satisfaction scores (patient’s rating of whether patients are getting timely care, appointments and information).
Project Option- 2.9.2 “Other” project option: MHMD Care Management

Unique RHP Project Identification Number: 020834001.2.2
Performing Provider Name/TPI: Memorial Hermann Hospital System/TPI 020834001

Project Description:

Implementation of comprehensive care management infrastructure across the continuum of care for populations attributed to the MHMD Clinical Integrated Network of Patient Centered Medical Home (PCMH) practices, embedding care managers into those practices, tracking patient compliance with referral patterns and assigning Case Managers (CMs) to emergency department, inpatient discharges, and high risk patients. These activities will serve all the attributed PCMH patients in Harris, Montgomery, and Fort Bend counties. Memorial Hermann has developed a pilot project for a comprehensive care management structure. This project will initially be implemented for patients seen by the Memorial Hermann Physician Network (“MHMD”). MHMD is a clinically integrated physician organization comprised of more than 3,500 doctors throughout the greater Houston area (2,500 in clinical integration (CI) and 750 in Patient Centered Medical Home (PCMH)). Founded in 1982, MHMD is the largest clinically integrated physician organization in Texas. MHMD physicians are experienced and board certified, with conveniently located clinical practices throughout the region. If the pilot project proves successful then Memorial Hermann will implement the same model for the rest of its patient population.

MHMD promotes member health and well-being by actively coordinating services and providing educational support to members and their families, who are living with multiple or complex chronic conditions. The Complex Care Coordination Program fulfills this role by helping patients access needed resources. Eligible members are proactively identified by their Primary Care Physician, specialist referral, review of emergency room utilization, claims data, hospital discharge data, as well as pharmacy utilization data.

The Complex Care Program consists of two main components, Complex Care Coordination Services, and Pathways for Life Services, both of which offer a multidisciplinary, continuum-based, patient focused approach to primary health care delivery that proactively identifies populations with complex or multiple chronic medical conditions. Using this team approach, the Complex Care Service emphasizes prevention of exacerbations and complications; and increases focus on patients’ and family caregivers’ role, needs and goals. The Pathways for Life Service, encourages patients and their families to discuss and consider decisions in advance, about their preferences for treatment when an illness begins to affect their quality of life. This is accomplished by supporting the physician-patient relationship, developing a plan of care, and facilitating health care communications across all settings.

Members are routinely followed by an assigned licensed Care Manager who receive:

- Care Coordinator calls a minimum of twice (2x) monthly
- Health education to patient and caregivers as needed, including promoting self-management
- Medication reconciliation
- Coordination of care as directed by the member’s PCP and specialists, including facilitation of access
- Assessment for and identification of the need for home visits, and relaying need to PCP or specialist
- Expedited access to community resources and social services
- Increased support and care coordination during transitions in care
- Transitional calls and disease management services.

**Goal(s) and relationship to Regional goal(s):**

**Project Goal(s):**

The goal of this project is to utilize community health workers, case managers, or other types of health care professionals as patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. Patient navigators will help and support these patients to navigate through the continuum of healthcare services. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations. The goal in implementing this Patient Care Navigation program is to improve at-risk patients’ experience of the healthcare delivery system by demystifying the often lengthy process of diagnosis and treatment, by assisting with scheduling appointments and keeping up with treatment regimens, and by providing professional support to patients and their families where and when needed.

This project meets the following Region 3 goals:

This project addresses the RHP’s goal to “Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.” Memorial Hermann views the Waiver as an opportunity to develop innovative methods of care delivery that will: a) improve outcomes for patients; b) increase access to care; and c) lower the cost of care in the Region. In keeping with those goals, Memorial Hermann developed a pilot project for a comprehensive care management structure. This project will initially be rolled out using Memorial Hermann’s physician group. The project is initially limited to this subset of patients because Memorial Hermann has greater control over its own physicians, which will allow it to more easily fine tune and adapt the program to changing circumstances or unforeseen obstacles. If the pilot project proves successful then Memorial Hermann will implement the same model the rest of its patient
population, including Medicaid and indigent. Memorial Hermann believes that testing innovative models on a smaller population in order to translate those lessons learned to the Region and eventually the State is precisely the intention of the Waiver.

**Challenges and how addressed:**

We have created a model that embeds care managers in the physicians’ offices, to create direct responsibility for the population in each practice. Challenges will be centered around timely and accurate data, connectivity of information systems, communication, and creation of clinical data repositories to inform physicians and care managers. Memorial will address those challenges by putting in place processes which will promote timely and accurate data.

**5-year expected outcome for provider and patients:**

MHMD has a population of patients for which we have accountable responsibility, from Medicare to commercial populations. We anticipate the number of patients will total about 160,000 by January 1, 2013. We expect our care managers will interface heavily with the most chronically ill patients and focus on condition and continuum of care management.

**Starting Point/Baseline:** Memorial does not currently have a care management program.

**Rationale:**

Region 3 suffers from higher-than-average at-risk rates when compared to the statewide average. Coordination of care for patients, improves patient quality of life and healthcare cost effectiveness with decreased emergency room visits, decreased hospital length of stay, and decreased end-of-life hospital admissions. Patient navigators help patients and their families navigate the fragmented maze of doctors’ offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system.

**Project components:**

Required core project components:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.

- Memorial care managers and information systems will identify frequent patients both at risk for future hospitalization as well as those that are currently high utilizers of ED services. Program elements will focus on proactive management of this population.

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.

- Memorial will deploy care managers and other allied health personnel as necessary to help at risk patients enroll in chronic disease management programs and engage with their primary care physicians. These efforts will be guided by stratification of the
population based on evidence based clinical protocols and outcomes data. This data will suggest the best methods to manage the disease incidence within the population.

c) Connect patients to primary and preventive care

- Chronic disease programs combined with primary care intervention will be a core component of this effort. Memorial programs will focus on the most costly and high incidence patients. These support programs will include education and clinical intervention.

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

- Create a series of “Joint Operation Councils” that will be multidisciplinary in nature, bringing together physician leadership, care managers, clinical informaticists and other allied health professionals to review progress and opportunities in managing at risk patients. The lessons learned from these forums will serve to inform our activities as we take on additional populations in the Memorial patient centered medical home.

Unique community need identification number the project addresses:
- CN1 – Primary Care

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

This will considerably improve Memorial’s capacity to deliver efficient behavioral healthcare.

Related Category 3 Outcome Measure(s): OD-6: Patient Satisfaction IT-6.1 Percent improvement over baseline of patient satisfaction scores: are patients getting timely care, appointments and information.

Reasons/rationale for selecting the outcome measure(s):
Patient satisfaction is a measure of this project’s success, as patients receive better access to and better information for services, their satisfaction will improve.

Relationship to other Projects: This project is part of Memorial Hermann’s larger plan to expand and develop primary care and specialty care services, while improving access to care and implementing delivery improvements targeted to specific populations (in this case, behavioral health patients).

Relationship to Other Performing Providers’ Projects in the RHP: TBD

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

**Project Valuation:**

The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

**Rationale/justification for valuation:** Establishing a patient navigation program will make more efficient use of the healthcare system and lower costs of care in the community — a vital goal of the Waiver. Memorial Hermann feels this value is justified by the transformative nature of this project. Memorial Hermann believes that testing innovative models on a smaller population in order to translate those lessons learned to the Region and eventually the State is precisely the intention of the Waiver. The project will also involve training hundreds of physicians in the new style of managing care. These physicians will be able to transfer the skills and institutional knowledge they gain from this project to all of their patients-producing a ripple benefit to the Region for many years past the Waiver.
**Milestone 1** [P-1]: Conduct a Needs Assessment to identify the patient population(s) to be targeted with the Patient Navigator Program

**Metric**: [P-1.1]: Provide report identifying targeted patient population characteristics; how the program will identify, triage, and manage patient population; number of navigators needed to be hired

**Data Source**: Program documentation, EHR, claims, needs assessment survey

**Goal**: To target populations to improve the efficiency of the project.

**Milestone 2** [P-X]:

**Process**: Establish baseline for number of target population reached by patient navigators.

**Metric**: Establish baseline for future years.

**Data Source**: Submission of documentation demonstrating study of baseline numbers.

<table>
<thead>
<tr>
<th>Year</th>
<th>Outcome Measure(s)</th>
<th>Percent Improvement Over Baseline of Patient Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>020834001.3.8</td>
<td>IT-6.1</td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 4** [P-2]: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education.

**Metric** [P-2.3]: Frequency of contact with care navigators for high risk patients.

**Data Source**: Patient navigation program materials and database, EHR.

**Baseline/Goal**: Increase patient contact by 5% over baseline measured in DY 2.

**Milestone 5**

**CQI**: P-8 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects

**Metric**

**Milestone 8** [P-2]: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education.

**Metric** [P-2.3]: Frequency of contact with care navigators for high risk patients.

**Data Source**: Patient navigation program materials and database, EHR.

**Baseline/Goal**: Increase patient contact by 10% over baseline measured in DY 2.

**Milestone 12** [P-2]: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education.

**Metric** [P-2.3]: Frequency of contact with care navigators for high risk patients.

**Data Source**: Patient navigation program materials and database, EHR.

**Baseline/Goal**: Increase patient contact by 15% over baseline measured in DY 2.

**Milestone 13**

**CQI**: P-8 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects

**Metric**

**CQI**: P-8.1 Number meetings, conference calls or webinars organized by the RHP that the provider participated in.
<table>
<thead>
<tr>
<th>020834001.2.2</th>
<th>2.9.2</th>
<th>A-E</th>
<th>“OTHER” PROJECT OPTION: MHMD CARE MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 3</td>
<td>Outcome Measure(s):</td>
<td>Percent Improvement Over Baseline of Patient Satisfaction</td>
<td></td>
</tr>
<tr>
<td>020834001.3.8</td>
<td>IT-6.1</td>
<td>020834001</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
</tr>
<tr>
<td>CQI: P-8.1 Number meetings, conference calls or webinars organized by the RHP that the provider participated in.</td>
<td>CQI: P-8.1 Number meetings, conference calls or webinars organized by the RHP that the provider participated in.</td>
<td>CQI: P-8.1 Number meetings, conference calls or webinars organized by the RHP that the provider participated in.</td>
<td>CQI: P-8.1 Number meetings, conference calls or webinars organized by the RHP that the provider participated in.</td>
</tr>
<tr>
<td>Data Source</td>
<td>Data Source</td>
<td>Data Source</td>
<td>Data Source</td>
</tr>
<tr>
<td>Meeting Agendas, sign-in sheets, conference calls, presentations, email</td>
<td>Meeting Agendas, sign-in sheets, conference calls, presentations, email</td>
<td>Meeting Agendas, sign-in sheets, conference calls, presentations, email</td>
<td>Meeting Agendas, sign-in sheets, conference calls, presentations, email</td>
</tr>
<tr>
<td>Milestone 3:</td>
<td>Milestone 6:</td>
<td>Milestone 10:</td>
<td>Milestone 15:</td>
</tr>
<tr>
<td>CQI: P-8 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects</td>
<td>CQI: P-3 Provide care management/navigation services to targeted patients.</td>
<td>CQI: P-3 Provide care management/navigation services to targeted patients.</td>
<td>I-6 Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services.</td>
</tr>
<tr>
<td>Metric</td>
<td>Metric</td>
<td>Metric</td>
<td>Metric</td>
</tr>
<tr>
<td>CQI: P-8.1 Number meetings, conference calls or webinars organized by the RHP that the provider participated in.</td>
<td>CQI: P-3.1 Increase in the number or percent of targeted patients enrolled in the program</td>
<td>CQI: P-3.1 Increase in the number or percent of targeted patients enrolled in the program</td>
<td>I-6.4 Percentage of patients without a medical home who use the ED, urgent care and/or hospital services.</td>
</tr>
<tr>
<td>Numerator: Number of targeted patients enrolled in the program</td>
<td>Numerator: Number of targeted patients enrolled in the program</td>
<td>Numerator: Number of targeted patients enrolled in the program</td>
<td>Numerator: Number of targeted patients enrolled in the program by 5%.</td>
</tr>
<tr>
<td>Denominator: Total number of targeted patients identified</td>
<td>Denominator: Total number of targeted patients identified</td>
<td>Denominator: Total number of targeted patients identified</td>
<td>Denominator: Total number of targeted patients identified by 15%.</td>
</tr>
<tr>
<td>Baseline/Goal: Increase number of patients enrolled in program by 5%.</td>
<td>Baseline/Goal: Increase number of patients enrolled in program by 10%.</td>
<td>Baseline/Goal: Increase number of patients enrolled in program by 15%.</td>
<td>Data Source: Enrollment reports</td>
</tr>
<tr>
<td>Data Source: Enrollment reports</td>
<td>Data Source: Enrollment reports</td>
<td>Data Source: Enrollment reports</td>
<td>Data Source: Enrollment reports</td>
</tr>
<tr>
<td>Milestone 11: I-6 Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### “OTHER” PROJECT OPTION: MHMD CARE MANAGEMENT

**Memorial Hermann Hospital System**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>020834001.3.8</th>
<th>IT-6.1</th>
<th>Percent Improvement Over Baseline of Patient Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 7</strong>:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I-6. Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 I-6.4 Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: 5% increase over baseline.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1 I-6.4 Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: 5% increase over baseline.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Approximately 186,900 patients will be served)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>primary care provider who are given a scheduled primary care provider appointment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: 5% increase over baseline.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Approximately 195,800 patients will be served)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Milestone Bundle Amount</strong>: $4,097,086</td>
<td><strong>Year 3 Estimated Milestone Bundle Amount</strong>: $4,469,701</td>
<td><strong>Year 4 Estimated Milestone Bundle Amount</strong>: $4,482,694</td>
<td><strong>Year 5 Estimated Milestone Bundle Amount</strong>: $3,703,095</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**: $16,752,577
Memorial Medical Center

Pass 2
Project Option 2.5.4-Implement other evidence-based project that will impact cost efficiency in an innovative manner: Medication Dispensing Safety & Efficiency

Unique RHP Project ID: 137909111.2.1
Performing Provider Name/TPI: Memorial Medical Center / 137909111

Project Summary:
Provider:
Memorial Medical Center is a county-owned, 25 bed Critical Access Hospital and serves as the only hospital for Calhoun County. Located on the Gulf Coast, Memorial Medical Center serves 60% of the 21,382 County residents. With a tax base of $13,972,000, Memorial Medical Center was able to provide more than $8 million in charity care (includes uncompensated) during FY 2012.

<table>
<thead>
<tr>
<th>Volume Statistics –11 months</th>
<th>Patient Payer Mix for Inpatient Services</th>
<th>Patient/Community Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year to date 2011 - 2012</td>
<td>Hospital admissions- 1056</td>
<td>Medicaid and CHIP- 18%</td>
</tr>
<tr>
<td></td>
<td>Births (babies delivered)- 98</td>
<td>Medicare- 53%</td>
</tr>
<tr>
<td></td>
<td>Emergency visits- 9084</td>
<td>Commercial Insurance- 19%</td>
</tr>
<tr>
<td></td>
<td>Outpatient visits- 13,430</td>
<td>Uninsured, Charity, Indigent Care- 10%</td>
</tr>
<tr>
<td></td>
<td>Laboratory procedures- 224,562</td>
<td>Hispanic- 47.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>African American- 3.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Caucasian- 44.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Asian- 4.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>American Indian- 0.7%</td>
</tr>
</tbody>
</table>

Intervention(s):
The automation of a medication dispensing system significantly increases pharmacist and nursing staff time to spend on patient care and education; reduce pick errors for wrong medications increasing patient safety; and facilitate cost containment/savings due to the addition time allowed for pending expired medication to be disposed compared to the regulations for disposal via a manual model, efficiency in labor and reduction in needed supplies.

Need for the project:
The purpose of this project is to provide cost containment, improved patient care and safety. Currently, our nursing staff spends 1.5 to 2 hours per patient ordering, receiving and administering medication. With a dispensing system in place, 95% of the medications administered in a care area would be stored for ready access. This method allows for "now orders" on medication which in return leads to better patient services by keeping the patient more comfortable. Pharmaceutical automation will provide 99.99% prescription dispensing accuracy for improved medication safety.

Target Population:
All patients within the system with may benefit from this project (Medicaid and CHIP-18% / Medicare- 53%), specifically those with chronic diseases.

Category 1 or 2 expected patient benefits:
Through the medication dispensing project, MMC plans to provide increased efficiency and safety in delivery of pharmaceutical services along with increased access to one-on-one nursing care. Net cost savings are approximately $712,000 through use of automation as compared to the current manual prescription processing.

Category 3 outcomes:
OD-5: The value of the project is based on cost avoidance, projecting savings associated with reducing the costs incurred in filling 120,000 current patient prescriptions on an annual basis all the while improving patient satisfaction and experience. In DY5, cost savings result from a 31% decrease from baseline in the average labor cost per prescription using the total salaries and benefits/total number of MMC automated prescriptions as found on the monthly operating statement compared to baseline. The cost savings are a result of automation efficiencies.
Project Option 2.5.4- “Other” project option: Implement other evidence-based project that will impact cost efficiency in an innovative manner: Medication Dispensing Safety and Efficiency

Unique RHP Project Identification Number: 137909111.2.1
Performing Provider Name/TPI: Memorial Medical Center / 137909111

Project Description:
Currently, Memorial Medical Center has no automated prescription counting technology. Annually, 120,000 prescriptions are counted manually, using only a counting tray and spatula. According to HealthMEDX, on average, 74% of a typical nurse's workday is spent outside of the patient room on non-value added activity. Currently, our nursing staff spends 1.5 to 2 hours per patient ordering, receiving and administering medication. With a dispensing system in place, 95% of the medications administered in a care area would be stored for ready access. This method allows for "now orders" on medication which in return leads to better patient services by keeping the patient more comfortable. To avoid errors during the administration of medications, we would implement bedside bar-code scanning utilizing Computers on Wheels (COWS). Further, by using a dispensing system with COWS, nursing staff will have more time to spend with the patients assisting with their recovery process resulting in decreased length of stay and cost savings.

The benefits of a Medication Dispensing System include improved patient services, safety, and cost efficiency. Focused on safety, high-risk drugs are stored in high-security pockets allowing less room for error and threat of diversion minimized. Since only one pocket opens up with one medication, nurses are restricted from the wrong medication during dispensing or take one that they aren't authorized to take. The ability to layout medications in the order allows staff to keep look-alike and sound-alike drugs far away from each other which substantially reduces the risk of "pick errors". This type of "checks and balances" further assures patients receive the correct medication in most efficient process possible. Pharmaceutical automation will provide 99.99% prescription dispensing accuracy for improved medication safety.

Project managers will consist of an interdisciplinary team of pharmacy, IT, and planning representatives.

Goals and Relationship to Regional Goals:
Project Goals:
• Implement an in-house automated medication dispensing system that can process up to 10,000 prescriptions per day with the capability of increasing volume at a negligible cost.
• Decreasing the average labor cost per prescription from baseline.
• Engineering pharmacy operations to develop a patient centered delivery model ensuring comprehensive medication management for optimal outcomes.
• Enhancing patient satisfaction by decreasing pharmacy wait times and increasing nursing and pharmacy access.
• To become a provider of choice for our patients and for the medically underserved individuals and families of Calhoun County.

This project meets the following regional goals:
• Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and
improves health care outcomes and patient satisfaction. The MMC medication dispensing system will improve efficiency in the pharmacy and improve patient satisfaction with improved wait times and patient adherence.

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system. The MMC Medication Dispensing project will allow on site pharmacists to focus on clinical patient centered activities such as Medication Therapy Management. These programs promote patient adherence and wellness as well as decrease emergency room visits for refills.

- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes. Automation technology represents best practices currently in use by the Veterans Administration, the United States Armed Services, as well as other public hospitals and retail pharmacy services.

Challenges:
- Funding – this is addressed by the DSRIP project.
- Software operating system - the pharmacy software operating system will be transitioned to operating system that supports medication dispensing and interfaces with CPSI (our current patient care system).
- Project development – Due to the large scale nature of the project, the medication dispensing DSRIP project will be supported by a multidisciplinary team including; an Information Technology (IT) project manager, Planning project manager and Pharmacy project manager.
- Limited personnel decreasing the amount of time spent with patients.
- Training staff on medication safety and use of a new system.

With the implementation of an automated medication dispensing system, several stages of development must occur. First the installation and interface with the current patient care system must take place including the input of the pharmaceutical inventory. Once systems are in place, we will train the staff on how the system functions. We will implement hospital departments one at a time and use staff to assist their co-workers with training.

5-Year expected outcome for Provider and Patients: Through the medication dispensing project, Memorial Medical Center plans to provide increased efficiency and safety in delivery of pharmaceutical services along with increased access to one-on-one nursing care. Net cost savings are approximately $712,000 through use of automation as compared to the current manual prescription processing. This estimate is based on the current 120,000 prescription volume.

Starting Point/Baseline:
Currently, all prescriptions (approximately 120,000 annually) at Memorial Medical Center are manually filled on site by frontline pharmacy staff with no available automation. Patients and Nursing Staff either wait for their prescriptions or come back at a later date. Efficiency, safety and access would be greatly enhanced with the creation of a dispensing system.

Rationale:
Project option 2.5.4, “Other” project option: Implement other evidence-based project that will impact cost efficiency in an innovative manner, was chosen to justify the pharmacy prescription processing redesign for cost containment. The Memorial Medical Center Department of Pharmacy is committed to providing high quality pharmacy services in the most cost effective and efficient manner through implementation of an automated medication dispensing system. Memorial Medical
Center serves approximately 28,000 unduplicated lives, and the Department of Pharmacy currently fills approximately 120,000 prescriptions per year at one pharmacy located in the hospital. Pharmaceutical services at MMC are currently 100% manual. It is expected that approximately 90% of the total Memorial Medical Center prescription volume could be efficiently processed by an automated dispensing system. These medications would consist primarily of maintenance medications for chronic disease conditions. The automated system would afford time for the on-site clinical pharmacist to provide expanded clinical services as such as Medication Therapy Management (MTM), and nursing staff to extend patient care. These clinical value added benefits enhance the efficiency and significance of the redesign. Furthermore, the MMCMedication Dispensing Project will lend to cost containment as associated with expired medications. Under a non-automated model, pharmacists are required to pull expiring medications three months before their expiration date. Although still useful, these medications are destroyed long before necessary causing waste and financial loss. Under an automated system, medications are pulled days before their due date resulting in a cost savings.

This project will target all residents of Calhoun County. The total inpatient impact is expected to be approximately 28,000 patients. Approximately 50% of patients are either Medicaid eligible or indigent, so we expect Medicaid and the uninsured will be beneficiaries of these services.

**Project Components:**
No core components are required for this initiative.

**Milestones & Metrics:**
Process Milestones and Metrics: P-X2, P-X2.1
Improvement Milestones and Metrics: I-X8, I-X8.1

**Unique Community need identification numbers the project addresses:**
CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including cancer, diabetes, obesity, cardiovascular disease, asthma and AIDS/HIV. The automated prescriptions filled at MMC are primarily refills for chronic disease conditions. The efficiencies gained with this project will allow the pharmacist on site, to focus on urgent need prescriptions, e.g. antibiotics, pain, seizure medications. On site pharmacist will also have more time to focus on clinical functions such as Medication Therapy Management (MTM).

MMC’s primary service area is almost exclusive to the Port Lavaca zip code. The secondary service area includes the remainder of Calhoun County and the southwestern portion of adjacent Matagorda County. To better understand the community’s needs and determine the steps MMC needs to take to adequately serve the region’s patients, in 2010 MMC contracted with BR Healthcare Services, Inc. (BRHS) to conduct an analysis of MMC’s current market, the primary and secondary service area, demographics, and outmigration. The study found that 73% of patients served by MMC lived in the Port Lavaca zip code area, while 18% of patients lived in Calhoun County and Palacios. During the time period of the study, the patient population included 33.6% who are covered by Medicare; 16.4% who are covered by Medicaid; 31.1% who are insured by a commercial plan; and 18.9% who are uninsured, charity and indigent care patients.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
The automation of a medication dispensing system significantly increases pharmacist and nursing staff time to spend on patient care and education. With hundreds of prescriptions filled per day an automated system also reduces pick errors for wrong medications increasing patient safety. In

---

addition, an automated system facilitates cost savings due to the addition time allowed for pending expired medication to be disposed compared to the regulations for disposal via a manual model.

We will improve efficiencies by increasing the percentage of prescriptions filled by the automated dispensing system. There is currently no automation at Memorial Medical Center, therefore the baseline percentage of prescriptions filled via an automated system is 0%. The first partial year consisting of 4 months automated medication dispensing, ending in DY3, is expected to meet a goal of filling 20% of the total monthly prescription volume at the facility. We anticipate a cost savings in labor of $32,850 over baseline from implementation in the Emergency Department alone.

Approximately 50% of the total prescription volume is for chronic disease medications. In DY4, the percent of prescriptions filled through an automated system will increase by 70% to a goal of 90% over baseline with the addition of inpatient departments. We anticipate a cost savings in labor and supplies equal to $496,800. In DY5, the percent of automated prescriptions filled will remain at 90% over baseline. However, the recapture costs through tracking medication dispensed in the Emergency Department and the retention of expiring medication until their due date will add a total cost savings through the lifetime of the Waiver to $712,000.

**Related Category 3 Outcome Measure(s):**
OD-5 Cost of Care
IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery
The automated dispensing redesign for pharmacy services at Memorial Medical Center will result in cost savings through increased efficiencies in the delivery of pharmaceutical services and availability of nursing staff to provide value added tasks for the patients. Automation will help keep labor costs in check while our frontline staff can focus on clinical efforts for our patients. The pharmacist will be readily available for counseling patients on medication adherence.

We will utilize the Cost Benefit Analysis to demonstrate costs and outcomes in monetary units. We propose incremental cost savings as the project goes from zero automation at baseline in DY2 to 90% automation by the end of DY5. We expect to decrease the average labor cost per prescription by 7% by the end of the initial DY3 implementation year. In DY4, we expect a 19% decrease from baseline in the average labor cost per prescription. In DY5, we expect a 31% decrease from baseline in the average labor cost per prescription. We will use a report to be generated from the new software operating system to determine the percentage of prescriptions filled through the automated system. The monthly operating statements will be used to show comparative cost savings in total salaries and benefits and the total number of prescriptions filled at MMC. Projected cost savings are based on current 120,000 annual prescription volume.

**Relationship to other Projects:**
The increase of primary care and specialty care will naturally result in additional ambulatory care encounters for our region patient base. The ambulatory initiatives cover items such as laboratory, PT/OT, social work, etc. and are a necessity of our patients to ensure a comprehensive treatment for access as well as cost avoidance. The Region 3 initiative grid in the addendum reflects all ambulatory operations initiatives.

**Plan for Learning Collaborative:** We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.
**Project Valuation:**
This project is a supporting pillar for one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in Calhoun County. The value of the project is based on cost avoidance, projecting savings associated with reducing the costs incurred in filling 120,000 current patient prescriptions on an annual basis. Based on the increase in primary care volumes addressed in another Memorial Medical Center Waiver project (137909111.1.1), further growth in volume to prescriptions is projected. Despite this increase in prescription volume, processing costs are projected to decrease in total with the addition of the automated medication dispensing function. The prompt availability of needed prescriptions for our underserved patients, particularly those with chronic disease that can be managed effectively with appropriate pharmaceuticals, will result in fewer emergency room visits for public and private hospitals located in the service area, and will also help to prevent future downstream inpatient admissions.

This project will target all residents of Calhoun County. The total inpatient impact is expected to be approximately 28,000 patients. Approximately 50% of patients are either Medicaid eligible or indigent, so we expect Medicaid and the uninsured will be beneficiaries of these services.

We value this project based upon labor costs for Pharmacist and Nursing staff. Further, cost savings generated by the elimination of labeling medications and destroying medications before their expiration date. In addition, the value associated with one-on-one patient care, medication counseling and the elimination of potentially fatal pick errors adds another layer of value to the patients we serve.
# MEDICATION DISPENSING SAFETY AND EFFICIENCY

**Memorial Medical Center**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Improved cost savings: Demonstrate cost savings in care delivery</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>

**Milestone 1**

[P-X1]: Establish a baseline for percentage of prescriptions processed via automated dispensing system

**Metric 1 [P-X1.1]:** Baseline is 0% since there is no current automation

**Goal:** Provide documentation of 0% baseline (current state)

**Data Source:** software operating system reports TBD

**Milestone 1 Estimated Incentive Payment (maximum amount):** $29,148

**Milestone 2**

[P-X2]: Complete a planning process and submit a plan

**Metric 1 [P-X2.1]:** Implementation of Automated Medication Dispensing System

**Goals:**
- Complete pharmacy operating system transition
- Complete automated medication dispensing build out
- Go-live with automated dispensing
- Fill 20% of total prescription volume via automated system

**Data Source:** project coordinators

**Milestone 4 Estimated Incentive Payment:** $51,797

**Milestone 3**

[P-X3]: Complete a planning process and submit a plan

**Metric 1 [P-X3.1]:** Demonstrate cost savings in care delivery

**Goal:** Decrease time from the time prescription is ordered to the time administered to patient by 10 minutes utilizing an automated dispensing system versus manual dispensing. Increase prescriptions filled through an automated system will increase by 70% to a goal of 90% over baseline with the addition of inpatient departments, resulting in 19% decrease from baseline in the average labor cost per prescription.

**Data Source:** Software operating system reports/Cost Benefit Analysis

**Milestone 3 Estimated Incentive Payment:** $52,937

**Milestone 4**

[P-X4]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.

**Metric 1 [P-X4.1]:** Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.

**Goal:** Decrease time from the time prescription is ordered to the time administered to patient by 30 minutes utilizing an automated dispensing system versus manual dispensing. The percent of automated prescriptions filled will remain at 90% over baseline, however, we expect a 31% decrease from baseline in the average labor cost per prescription.

**Data Source:** Software operating system reports/Cost Benefit Analysis

**Milestone 4 Estimated Incentive Payment:** $45,194

**Milestone 5**

[P-X5]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.

**Metric 1 [P-X5.1]:** Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.

**Goal:** Decrease time from the time prescription is ordered to the time administered to patient by 30 minutes utilizing an automated dispensing system versus manual dispensing. The percent of automated prescriptions filled will remain at 90% over baseline, however, we expect a 31% decrease from baseline in the average labor cost per prescription.

**Data Source:** Software operating system reports/Cost Benefit Analysis

**Milestone 5 Estimated Incentive Payment:** $45,194

**Milestone 6**

[I-8]: Improved cost savings

**Metric 1 [I-8.1]:** Demonstrate cost savings in care delivery

**Goal:** Decrease time from the time prescription is ordered to the time administered to patient by 10 minutes utilizing an automated dispensing system versus manual dispensing. Increase prescriptions filled through an automated system will increase by 70% to a goal of 90% over baseline with the addition of inpatient departments, resulting in 19% decrease from baseline in the average labor cost per prescription.

**Data Source:** Software operating system reports/Cost Benefit Analysis

**Milestone 6 Estimated Incentive Payment:** $52,937

**Milestone 7**

[I-9]: Improved cost savings

**Metric 1 [I-9.1]:** Demonstrate cost savings in care delivery

**Goal:** Decrease time from the time prescription is ordered to the time administered to patient by 30 minutes utilizing an automated dispensing system versus manual dispensing. The percent of automated prescriptions filled will remain at 90% over baseline, however, we expect a 31% decrease from baseline in the average labor cost per prescription.

**Data Source:** Software operating system reports/Cost Benefit Analysis

**Milestone 7 Estimated Incentive Payment:** $45,194

**Milestone 8**

[I-10]: Improved cost savings

**Metric 1 [I-10.1]:** Demonstrate cost savings in care delivery

**Goal:** Decrease time from the time prescription is ordered to the time administered to patient by 10 minutes utilizing an automated dispensing system versus manual dispensing. Increase prescriptions filled through an automated system will increase by 70% to a goal of 90% over baseline with the addition of inpatient departments, resulting in 19% decrease from baseline in the average labor cost per prescription.

**Data Source:** Software operating system reports/Cost Benefit Analysis

**Milestone 8 Estimated Incentive Payment:** $45,194

**Milestone 9**

[I-11]: Improved cost savings

**Metric 1 [I-11.1]:** Demonstrate cost savings in care delivery

**Goal:** Decrease time from the time prescription is ordered to the time administered to patient by 10 minutes utilizing an automated dispensing system versus manual dispensing. Increase prescriptions filled through an automated system will increase by 70% to a goal of 90% over baseline with the addition of inpatient departments, resulting in 19% decrease from baseline in the average labor cost per prescription.

**Data Source:** Software operating system reports/Cost Benefit Analysis

**Milestone 9 Estimated Incentive Payment:** $45,194
### MEDICATION DISPENSING SAFETY AND EFFICIENCY

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Year 2 Outcome Measure(s): 137909111.3.2</th>
<th>Year 3 Outcome Measure(s): [3] IT-5.1</th>
<th>Year 4 Outcome Measure(s):</th>
<th>Year 5 Outcome Measure(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memorial Medical Center</td>
<td>137909111</td>
<td>137909111</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3</strong> [P-7]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.</td>
<td><strong>Metric 1</strong> P-7.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in.</td>
<td>Improved cost savings: Demonstrate cost savings in care delivery</td>
<td><strong>Metric 1</strong> P-7.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in.</td>
<td><strong>Metric 1</strong> P-7.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in.</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
<td><strong>Data Source:</strong> Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
<td><strong>Data Source:</strong> Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
<td><strong>Data Source:</strong> Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
<td><strong>Data Source:</strong> Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
</tr>
<tr>
<td><strong>Metric 2</strong> P-7.2: Share challenges and solutions successfully during this bi-weekly interaction.</td>
<td><strong>Data Source:</strong> Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
<td><strong>Metric 2</strong> P-7.2: Share challenges and solutions successfully during this bi-weekly interaction.</td>
<td><strong>Data Source:</strong> Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
<td><strong>Metric 2</strong> P-7.2: Share challenges and solutions successfully during this bi-weekly interaction.</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
<td><strong>Data Source:</strong> Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
<td><strong>Data Source:</strong> Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
<td><strong>Data Source:</strong> Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
<td><strong>Data Source:</strong> Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.</td>
</tr>
<tr>
<td><strong>Metric 1</strong> Estimated Incentive Payment: $51,796</td>
<td><strong>Metric 2</strong> Estimated Incentive Payment: $52,936</td>
<td><strong>Metric 1</strong> Estimated Incentive Payment (maximum amount): $29,149</td>
<td><strong>Metric 1</strong> Estimated Incentive Payment (maximum amount): $29,149</td>
<td><strong>Metric 1</strong> Estimated Incentive Payment (maximum amount): $29,149</td>
</tr>
</tbody>
</table>

**Milestone 3 Estimated Incentive Payment (maximum amount): $29,149**

**Milestone 5 Estimated Incentive Payment: $51,796**

**Milestone 7 Estimated Incentive Payment (maximum amount): $52,936**

**Milestone 9 Estimated Incentive Payment (maximum amount): $45,195**
<table>
<thead>
<tr>
<th>Outcome Measure(s):</th>
<th>Improved cost savings: Demonstrate cost savings in care delivery</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

- **Year 2 Estimated Milestone Bundle Amount:** $87,445
- **Year 3 Estimated Milestone Bundle Amount:** $103,593
- **Year 4 Estimated Milestone Bundle Amount:** $105,873
- **Year 5 Estimated Milestone Bundle Amount:** $90,389

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5):* $387,300
Memorial Medical Center
Pass 3
Project Option 2.4.1-Improving the Patient Experience – The AIDET or similar project

**Unique RHP Project ID:** 137909111.2.2/Pass 3

**Performing Provider Name/TPI:** Memorial Medical Center / 137909111

**Project Summary:**
**Provider:**
Memorial Medical Center is a county-owned, 25 bed Critical Access Hospital and serves as the only hospital for Calhoun County. Located on the Gulf Coast, Memorial Medical Center serves 60% of the 21,382 County residents. With a tax base of $13,972,000, Memorial Medical Center was able to provide more than $8 million in charity care (includes uncompensated) during FY 2012.

<table>
<thead>
<tr>
<th>Volume Statistics –11 months Year to date 2011 - 2012</th>
<th>Patient Payer Mix</th>
<th>Patient/Community Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions- 1056</td>
<td>Medicaid and CHIP- 16.4%</td>
<td>Hispanic- 47.1%</td>
</tr>
<tr>
<td>Births (babies delivered)- 98</td>
<td>Medicare- 33.6%</td>
<td>African American- 3.3%</td>
</tr>
<tr>
<td>Emergency visits- 9084</td>
<td>Commercial Insurance- 31.1%</td>
<td>Caucasian- 44.4%</td>
</tr>
<tr>
<td>Outpatient visits- 13,430</td>
<td>Uninsured, Charity, Indigent Care- 18.9%</td>
<td>Asian- 4.5%</td>
</tr>
<tr>
<td>Laboratory procedures- 224,562</td>
<td></td>
<td>American Indian- 0.7%</td>
</tr>
</tbody>
</table>

**Intervention(s):**
Delay in seeking health care due to unsatisfactory patient experiences with customer service.

**Need for the project:**
The purpose of this project is to reduce patient anxiety and increase patient satisfaction. Process and measures will be implemented to measure and improve patient experiences resulting in improved communication. With improved satisfaction, there is potential to increase the level of care integration and coordination of the patient/doctor relationship and lead to better health and better patient experience of care.

**Target Population:**
All patients within the system with may benefit from this project (Medicaid and CHIP-16.4% / Medicare- 33.6%), specifically those with chronic diseases.

**Category 1 or 2 expected patient benefits:**
Over the course of this project, 100% full time and part time employees will participate in a patient experience training to improve patient satisfaction. By the end of DY 5, patient data experience will be available internally and externally for general public access and accountability. By doing so, we will improve the health of our clients by providing more timely access to care and coordinating treatment and follow-up care that isn’t available when patients seek treatment through the Emergency Department.

**Category 3 outcomes:**
OD-6: Because the community we serve has an insufficient number of providers and patients are often unable to obtain appointments in a timely manner, the priority goal for this project is ensuring patients receive care when they need it and without significant delays, which will result in improved health outcomes and patient satisfaction. In DY5, patient experience at the Hospital Based Clinic shall have improved in deficient areas of timely care, appointments and information by 10% by the end of the waiver.
Project Option 2.4.1 – Develop and implement a structured patient experience training program: Improving the Patient Experience – The AIDET or similar Project.

Unique RHP Project Identification Number: 137909111.2.2/Pass 3
Performing Provider Name/TPI: Memorial Medical Center / 137909111

Project Description:
Memorial Medical Center will develop and implement a structured patient experience training program: Improving the Patient Experience – The AIDET Project.

Memorial Medical Center is a 25-bed rural critical access hospital located in Calhoun County. The population of Calhoun County is 21,381 per the 2010 Census. The community of Port Lavaca has a population of 11,500 per the 2010 Census. Memorial Medical Center is the only hospital within Calhoun County. We provide basic services including Emergency Room, Diagnostic Imaging, Laboratory, Rehabilitation, Swing Bed, Surgery, ICU and Obstetric services.

Memorial Medical Center plans to roll out The AIDET Project or similar training program to all new and existing full-time and part-time employees. The AIDET program was developed by the Studer Group. It is a powerful communication tool. AIDET is an acronym for Acknowledge, Introduce, Duration, Explanation and Thank You. When interacting with patients, gaining trust is essential for obtaining patient compliance and improving clinical outcomes. The project goal is to reduce patient anxiety and increase patient satisfaction which will result in positive outcomes for the patient.

We expect to incur scheduling difficulties amongst the targeted population; however, in addition to the live training program that will be conducted, we will also implement a self-study web-based program, so we can accommodate various schedules. By the end of the waiver, our expected outcome is to have 100% of our full-time and part-time employees trained on the patient experience training program, and for the employees and public to be educated on our efforts of improving patient satisfaction for our patients and their families. This project helps achieve the overall goals of the region by promoting positive healthcare experiences throughout the region which will ultimately improve the health of patients and decrease healthcare costs.

Starting Point/Baseline:
The starting point/baseline for this project will be the number of new full-time and part-time employees and the number of existing full-time and part-time employees. As of October 1, 2012, we are expecting to train 141 full-time employees and 60 part-time employees. The number of new full-time and part-time employees is unknown at this time. The time period for this baseline is one year from October 1, 2012 – September 30, 2013; however, we will continue to provide patient experience training even after this date in order to continue our quality improvement process.

Rationale:
Our rationale for selecting project option 2.4.1 Implement processes to measure and improve patient experience was a result of the need for improved communication between patients and healthcare providers. We believe if we can increase patient satisfaction, it has the potential to increase the level of care integration and coordination of the patient/doctor relationship and lead to better health and better patient experience of care.

Project Components:
All core components will be addressed in this project:
a) Organizational integration and prioritization of patient experience;

b) Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience;
c) Implementing processes to improve patient’s experience in getting through to the clinical practice; and
d) Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures,

Challenges:
The primary challenge for this project will be to overcome the existing culture of a traditional model of medical care. To overcome this challenge, the MMC Administration will engage the staff in multiple educational sessions emphasizing the proven success of the AIDET model. Champions will be identified and empowered to bring about change. MMC, like most healthcare providers, experienced major financial challenges and resulting cutbacks. Two areas eliminated were staff development and education. The results have been missed opportunities to educate on best practices for positive patient outcomes. By educating our staff and implementing a customer service driven way of thinking and practice, we anticipate transforming the existing culture of medical care with our “new” interaction with patients, and gaining their trust which is essential for obtaining patient compliance and improving clinical outcomes.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
We believe the need for this project could fall under several of the needs reported in the RHP #3 Community Needs Assessment list, but it best is categorized under CN.23 Lack of patient navigation, patient and family education and information programs. If a patient has a good experience, we believe they will continue to actively engage themselves in their future health related care which will ultimately lead to positive outcomes and lower overall healthcare costs. We are not aware of any related activities to this project that are funded by the US Department of Health and Human Services currently ongoing or coming up in the future.

Related Category 3 Outcome Measure(s):
OD-6 Percent improvement over baseline of patient satisfaction scores. We intend to use the CG-CAHPS survey to improve our performance as measured by whether patients are (1) getting timely care, appointments and information. Obtaining patient feedback on our ability to provide the right care at the right time is critical to the success of this project and the internal operations of the clinic and hospital. This data will provide us with meaningful and objective information that will be used to determine whether our clinic has met patient expectations related to obtaining timely care and information, and will identify areas where we need to improve. Because the community we serve has an insufficient number of providers and patients are often unable to obtain appointments in a timely manner, the priority goal for this project is ensuring patients receive care when they need it and without significant delays, which will result in improved health outcomes and patient satisfaction. The CG-CAHPS survey is an effective tool for measuring our progress and will provide valuable information and feedback on our performance and areas where improvement is needed.
Reasons/rationale for selecting the outcome measures:
We believe if we can decrease patient anxiety and improve patient satisfaction in the rural setting when the patient is referred to the urban setting for extended/expanded healthcare that they will be more receptive and compliant to their healthcare needs which will ultimately lead to positive outcomes, improved patient satisfaction and ultimately lower healthcare costs. When patients perceive healthcare as a positive process, they will practice healthy lifestyles which results in lower healthcare costs.

We will focus on the stand-alone measure that will monitor an increase in patient satisfaction scores for the measure - patient is getting timely care, appointments, and information. We believe this measure is very important to the overall patient experience. These outcomes are important to our hospital because we believe if patients felt comfortable with the timeliness of their care, they would be less anxious about healthcare processes and more open to working with the healthcare providers. We believe by improving the patient experience through our Category 2 project – developing and implementing a structured patient experience training program, the patient will feel optimistic about their healthcare experience and take care of themselves. Again, we believe by focusing on patient satisfaction for every patient, it will improve the health of low-income population as well as the total population.

Selecting this measure ensures that patient satisfaction with their care is continuously monitored, analyzed, and considered in improvement cycles. These activities then become a central aspect of the training and dissemination aspects of the project, which in turn assures incorporation and propagation of successful patient satisfaction activities throughout the Hospital and Hospital Based Clinic.

5-Year Expected Outcome for Provider and Patients: MMC anticipates establishing a training system focused on positive patient experiences to support care coordination for the community that can be expanded to the region. The provider also expects a decline in workforce turnover by implementing best practices and identifying employee and patient “Champions” in healthcare. By educating and providing a positive peer environment, the resulting effect will be experienced by the patients. Implementing practices focused on a coordinated care model staff members will lead patients in taking control of their health. If a patient has a positive experience, we believe they will continue to actively engage themselves in their future health related care which will ultimately lead to positive outcomes and lower overall healthcare costs.

Goals and Relationship to Regional Goals:
Through the creation and education of a hospital and clinic staff, this project will enable MMC to better meet the community and Region needs for health care services. The goals of this project are:

- Provide access to care during non-traditional hours for patients who work, care for children, do not have transportation, or face other challenges that make it difficult for them to seek care during typical business hours;
- Improve health care outcomes by providing health care services that might not otherwise be available to residents and enabling patients to obtain more timely care before conditions become more serious and costly to treat;
- Reduce hospital readmissions by providing care coordination and patient follow-up when discharged from the hospital;
- Improve patient satisfaction by providing care in a more appropriate setting and reducing the wait time that typically accompanies visits to the emergency department.
While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following:

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

**Relationship to other Projects:** 137909111 1.1 Hospital Based Clinic improving access to Primary and Specialty Care.

**Relationship to Other Performing Providers’ Projects in the RHP:** Innovation is key to the transformation of healthcare in our community. The consistency of innovation in our region allows for increased improvements based on research trends, patient need, and provider availability. The waiver funding allows for innovation in specific areas and all innovative projects included in the plan are similar in the fact of program redesigns for historic treatments, and focus to chronic condition outcome measures such as central line infections. The Region 3 initiative grid in the addendum can provide a side by side comparison of all projects that directly relate to innovation.

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

**Project Valuation:** We valued the project based on cost and benefits to our organization. We believe if we can reduce patient anxiety through education, the patient will have positive experiences and positive outcomes which will make them to want to take care of themselves by leading healthier lives, obtaining preventative healthcare and seeking medical help at appropriate times. We believe with the improvement in patient satisfaction scores specifically the improvement target of patients getting timely care, appointments and information, this will decrease unnecessary Emergency Room visits, hospital stays, etc. because patients will be receiving the care and attention they need on a consistent and dependable basis. This Outcome Measure will serve the total outpatient and inpatient service populations of Memorial Medical Center, and it will ultimately assist Port Lavaca and the surrounding communities to live healthier lives and be healthier communities.

The value of a program such as AIDET to patients has many facets. Through the components taught, patient anxiety decreases, staff compliance increases, which results in improved clinical outcomes as well as increased patient and physician satisfaction. Utilizing
simple greetings are one way to ensure proper identification of patients and may well be considered a fundamental component of patient safety. Implementing and training staff of these simple steps will improve the lasting perception of very satisfying care. In addition:

• Demonstrate the culture of the organization by having consistent information shared with customers.
• Increase the comfort level of staff in communicating with patients.
• Improve patient’s experience.
• Engage patients in their care.
## IMPROVING THE PATIENT EXPERIENCE - THE AIDET PROJECT

**Memorial Medical Center**

**Related Category 3 Outcome Measure(s):** 137909111.3.3 [3.11-6.1(1)]

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1** [P-1]: Hire an executive accountable for experience performance and education.
- **Metric 1** [P-1.1]: Documentation of an executive assigned responsibility for experience performance and education.
- **Data Source:** Job description

**Milestone 1 Estimated Incentive Payment (maximum amount):** $35347

**Milestone 2** [P-15]: Develop a training program on patient experience.
- **Metric 1** [P-15.1]: Submission of training program materials.
- **Data Source:** Invoices and Curriculum

**Milestone 2 Estimated Incentive Payment:** $35347

**Milestone 3** [P-4]: Integrate patient experience training into new employee orientation training.
- **Metric 1** [P-4.1]: Percent of new full-time and part-time employees who received patient experience training as part of their new employee orientation.

**Milestone 3 Estimated Incentive Payment (maximum amount):** $56475

**Milestone 4** [P-4]: Integrate patient experience training into existing full-time and part-time employee training.
- **Metric 1** [P-4.1]: Percent of existing full-time and part-time employees who received patient experience training.

**Milestone 4 Estimated Incentive Payment (maximum amount):** $56475

**Milestone 5** [P-6]: Include specific patient and/or employee experience objectives into employee job descriptions and work plans. Hold employees accountable for meeting them.
- **Metric 1** [P-6.1]: Percent of employees who have specific patient and/or employee experience objectives in their job description and/or work plan.

**Milestone 5 Estimated Incentive Payment (maximum amount):** $56475

**Milestone 6** [P-6]: Integrate specific patient and/or employee experience objectives into employee job descriptions and work plans. Hold employees accountable for meeting them.
- **Metric 1** [P-6.1]: Percent of employees who have specific patient and/or employee experience objectives in their job description and/or work plan.

**Milestone 6 Estimated Incentive Payment:** $87430

**Milestone 7** [P-18]: Develop regular organizational display(s) of patient experience data (e.g., via a dashboard on the internal web) and provide updates to the employees on the efforts the organization is undertaking to improve the experience of its patients and their families.
- **Metric 1** [P-18.1]: Percent of employees who have specific patient and/or employee experience objectives in their job description and/or work plan.

**Milestone 7 Estimated Incentive Payment:** $87430

**Milestone 8** [P-19]: Make patient experience data available externally (e.g., via a dashboard on the external website) and provide updates to the general public on the efforts the organization is undertaking to improve the experience of its patients and their families.
- **Metric 1** [P-19.1]: Two external communications aimed at the general public’s understanding of the organization’s results and improvement efforts in the area of patient experience.

**Milestone 8 Estimated Incentive Payment:** $149143

**Milestone 9** [P-19]: Make patient experience data available externally (e.g., via a dashboard on the external website) and provide updates to the general public on the efforts the organization is undertaking to improve the experience of its patients and their families.
- **Metric 1** [P-19.1]: Two external communications aimed at the general public’s understanding of the organization’s results and improvement efforts in the area of patient experience.

**Milestone 9 Estimated Incentive Payment:** $149143
<table>
<thead>
<tr>
<th>137909111.2.2</th>
<th>2.4.1</th>
<th>2.4.1</th>
<th>IMPROVING THE PATIENT EXPERIENCE - THE AIDET PROJECT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Memorial Medical Center</strong></td>
<td></td>
<td></td>
<td><strong>137909111</strong></td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s):</strong></td>
<td></td>
<td><strong>Patient Satisfaction</strong></td>
</tr>
<tr>
<td>137909111.3.3</td>
<td>[3.IT-6.1(1)]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</th>
<th><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</th>
<th><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</th>
<th><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation. Baseline/Goal: Baseline = number of new full-time and part-time employees &amp; Goal = 75% of new full-time and part-time employees receive patient experience training. Data Source: Human Resource Records, sign in sheets for training compared to CPSI payroll report. New employee orientation checklist.</td>
<td><strong>Milestone 3 Estimated Incentive Payment (maximum amount):</strong></td>
<td><strong>$35347</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 4 [P-4]</strong> Integrate patient experience training into existing full-time and part-time employee training. Metric 1 [P-4.1]: Percent of existing full-time and part-time employees who received patient experience training. Baseline/Goal: Baseline = number of new full-time and part-time employees &amp; Goal = 75% of new full-time and part-time employees receive patient experience training. Data Source: Human Resource Records, sign in sheets for training compared to CPSI payroll report. New employee orientation checklist.</td>
<td><strong>Milestone 6 Estimated Incentive Payment:</strong></td>
<td><strong>$56475</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 7 [P-6]:</strong> Include specific patient and/or employee experience objectives into employee job descriptions and work plans. Hold employees accountable for meeting them. Metric 1 [P-6.1]: Percent of employees who have specific patient and/or employee experience objectives in their job description and/or work plan. Baseline/Goal: Baseline = number of employees who have specific patient experience training. Baseline/Goal: Baseline = number of employees &amp; Goal = 100% of employees to have specific patient and/or employee experience training. Data Source: Human Resource Records, sign in sheets for training compared to CPSI payroll report. New employee orientation checklist.</td>
<td><strong>Goal:</strong> Implement two displays to build awareness of patient experiences using real life examples. Data Source: Display and Internal Communication; screen shots of website, memos or photographs.</td>
<td><strong>Milestone 9 Estimated Incentive Payment:</strong></td>
<td><strong>$87430</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3</td>
<td>Outcome Measure(s):</td>
<td>Patient Satisfaction</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------</td>
<td>----------------------</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td>2012-2013</td>
<td>2013-2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(10/1/2012 – 9/30/2013)</td>
<td>(10/1/2013 – 9/30/2014)</td>
<td></td>
</tr>
<tr>
<td>Milestone 4</td>
<td>Estimated Incentive Payment: $35347</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 7</td>
<td>Estimated Incentive Payment: $56476</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td>2014-2015</td>
<td>2015-2016</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(10/1/2014 – 9/30/2015)</td>
<td>(10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td>Estimated Milestone Bundle Amount: $141,388</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td>Estimated Milestone Bundle Amount: $149,143</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5):* $634,817
Project Option 2.4.3-Improving the Patient Experience – Hospitalist Model

Unique RHP Project ID: 137909111.2.3

Performing Provider Name/TPI: Memorial Medical Center / 137909111

Project Summary:
Provider:
Memorial Medical Center is a county-owned, 25 bed Critical Access Hospital and serves as the only hospital for Calhoun County. Located on the Gulf Coast, Memorial Medical Center serves 60% of the 21,382 County residents. With a tax base of $13,972,000, Memorial Medical Center was able to provide more than $8 million in charity care (includes uncompensated) during FY 2012.

<table>
<thead>
<tr>
<th>Volume Statistics –11 months Year to date 2011 - 2012</th>
<th>Patient Payer Mix</th>
<th>Patient/Community Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions- 1056</td>
<td>Medicaid and CHIP- 16.4%</td>
<td>Hispanic- 47.1%</td>
</tr>
<tr>
<td>Births (babies delivered)- 98</td>
<td>Medicare- 33.6%</td>
<td>African American- 3.3%</td>
</tr>
<tr>
<td>Emergency visits- 9084</td>
<td>Commercial Insurance- 31.1%</td>
<td>Caucasian- 44.4%</td>
</tr>
<tr>
<td>Outpatient visits- 13,430</td>
<td>Uninsured, Charity, Indigent Care- 18.9%</td>
<td>Asian- 4.5%</td>
</tr>
<tr>
<td>Laboratory procedures- 224,562</td>
<td></td>
<td>American Indian- 0.7%</td>
</tr>
</tbody>
</table>

Intervention(s):
Due to the healthcare provider shortage, patients needing admission through the Emergency Department often experience delay in care.

Need for the project:
The purpose of this project is to eliminate the delay in care from the ER to inpatient services. MMC will research, design and implement if found to be effective a hospitalist model to increase productivity and access to care for patients involving both physicians and mid-level providers. Currently, patients are admitted to their primary care physician or the primary care physician on call for the ER. MMC works under contract with a team of rotating ER physicians resulting in issues with admitting patients and maintaining a care plan.

Target Population:
All patients within the system with may benefit from this project (Medicaid and CHIP-16.4% / Medicare- 33.6%), specifically those with chronic diseases.

Category 1 or 2 expected patient benefits:
Over the course of this project, the potential to yield improvements in the level of care integration and coordination for patients can ultimately lead to better health and better patient experience of care. Hospitalist will ensure patients’ needs are met within a timely manner reducing complications, lengths of stay, and the costs providing care. This project will target all residents of Calhoun County. The total inpatient impact is expected to be approximately 3000 patients via the Emergency Department. However, an average of 28,000 patients per year potentially could benefit by having a Hospitalist onsite for immediate patient care. Approximately 50% of patients are either Medicaid eligible or indigent, so we expect Medicaid and the uninsured will be beneficiaries of these services.

Category 3 outcomes:
OD-6: Because the community we serve has an insufficient number of providers and patients are often unable to obtain appointments in a timely manner, the priority goal for this project is
ensuring patients receive care when they need it and without significant delays, which will result in improved health outcomes and patient satisfaction. Through a Hospitalist Model we anticipate a 10% decrease in admission times by the end of the waiver.
Project Option 2.4.3 Patient Satisfaction

**Unique RHP Project Identification Number:** 137909111.2.3/Pass 3

**Performing Provider Name/TPI:** Memorial Medical Center / 137909111

**Project Description:**

*Hospitalist Model – Implementing processes to improve patient’s experience*

Memorial Medical Center is a 25-bed rural critical access hospital located in Calhoun County. The population of Calhoun County is 21,381 per the 2010 Census. The community of Port Lavaca has a population of 11,500 per the 2010 Census. Memorial Medical Center is the only hospital within Calhoun County. We provide basic services including Emergency Room, Diagnostic Imaging, Laboratory, Rehabilitation, Swing Bed, Surgery, ICU and Obstetric services.

Under this project, Memorial Medical Center will research, design, and implement (if found to be effective) a hospitalist model to increase productivity and access to care for patients, involving both physicians and mid-level providers. Under the current care model at our hospital, patient care is managed by individual primary care physicians who work in tandem with the hospital staff for their specific patients. Currently, there is a shortage of primary care physicians in Calhoun County and statewide that is causing lack of access to care. This lack of access is causing increased length of stay and decreased patient satisfaction. We would like to evaluate the possibility of implementing a hospitalist model, under which the hospital would have a staff of physicians and mid-level providers to treat hospital patients, in lieu of having primary care physicians make calls and visits on a fractured basis. Our research will determine if an all-physician hospitalist model would be appropriate or some type of mixed-model with mid-level providers is more effective. We expect to determine if and how much a hospitalist model will improve the patient experience by creating a more stable continuity of care during a hospital stay and providing easier access to doctors and nurses. Assuming the program is feasible and desirable, we expect that the move to a hospitalist model will improve patient satisfaction by reducing the wait time for treatment decisions, and will improve the documentation of patients’ diagnoses, treatment, and outcomes. The model should also improve the quality of life for physicians as they would no longer have to be on call or round in the middle of the night. Challenges include: high cost of providing the nurses and physicians; determining whether the hospitalist model will make a positive impact for patients; convincing primary care physicians that this model is better for their patients; accurately measuring the change in patient satisfaction.

**Goals and Relationship to Regional Goals:**

**Project Goals:** Assuming the program is feasible and desirable, we expect that the move to a hospitalist model will improve patient satisfaction by reducing the wait time for treatment decisions, and will improve the documentation of patients’ diagnoses, treatment, and outcomes. The model should also improve the quality of life for physicians as they would no longer have to be on call or round in the middle of the night.

This project meets the following regional goals: This project is tied to Region 3’s goal of increasing patient satisfaction through the delivery of high-quality, effective healthcare services. By providing an in-house hospitalist program, patients will receive greater access to healthcare professionals and more timely care resulting in lower lengths of stay and a better patient experience.
Challenges:
Challenges include: high cost of providing the nurses and physicians; determining whether the hospitalist model will make a positive impact for patients; convincing primary care physicians that this model is better for their patients; accurately measuring the change in patient satisfaction. This project will address these challenges by increasing the presence of Hospitalists in our facility, as well as providing training and information on how to work with a Hospitalist. Additionally, because there will be more physicians present in the hospital, patients will be seen more frequently and will have a better experience.

5-Year Expected Outcome for Provider and Patients:
The 5-year expected outcome of having a hospitalist program is to significantly increase patient satisfaction scores. These scores provide an indication of the patient experience and also help Memorial Medical Center address any deficiencies in a patient’s care that might prevent the best healthcare delivery possible. Higher patient satisfaction means a high-quality and effective healthcare service that is being provided. Further, we anticipate a significant decrease in time from Emergency Department to inpatient services attributed to the availability of an admitting Physician onsite.

Starting Point/Baseline:
Currently, patients are admitted to their primary care physician or the primary care physician on-call for the emergency department. Memorial Medical Center currently works under contract with an Emergency Department team of doctors on rotation. With a rotation scenario, a patient admitted under one doctor may not have the same physician the next day delaying care. Further, due to the shortage of primary care physicians, our physicians are over-burdened with their practice and often do not see patients in a timely manner. This causes delays in treatments which can lead to poor outcomes and increased lengths of stay. Occasionally, patients have been transferred to other towns because no primary care physician was available to admit them which resulted in delay of care. Occasionally, patients have been transferred to other towns because no primary care physician was available to admit them which resulted in delay of care.

Through this project, 7% of Emergency Room patients are currently admitted to inpatient services. Of these patients, 54% were Medicaid/Indigent. Without an admitting physician onsite, we estimate another 12% of patients are redirected by EMS out of the County for their healthcare needs. If a Hospitalist model is proven feasible, we estimate serving 29% of Emergency Department visits would receive increased access to timely care. With the support of local physicians, the referral rate could increase.

Rationale:
Implemented hospitalist projects have the potential to yield improvements in the level of care integration and coordination for patients and ultimately lead to better health and better patient experience of care. Currently, there is a shortage of primary care physicians in Calhoun County and statewide that is causing lack of access to care. This lack of access is causing increased lengths of stay and decreased patient satisfaction. We expect that the move to a hospitalist model will improve patient satisfaction by reducing the wait time for treatment decisions, and will improve the documentation of patients’ diagnoses, treatment, and outcomes. Hospitalists will
manage the acute care of patients and expedite the care of patients within the hospital setting. Hospitalists will ensure patients’ needs are met within a timely manner. Because hospitalists are on duty 24 hours a day, they are fully available to patients from admission to discharge. This reduces complications, lengths of stay, and the costs of providing care. This model will relieve some primary care physicians from rounding in the hospital, thus enabling greater patient access to care as physicians will be able to spend more time in their practice.

Project Components:
No core components are required for this project area.
This project will accomplish the following project components:

- Implement an innovative and evidence-based intervention that will lead to improvements in patient satisfaction for providers that have demonstrated need or unsatisfactory performance in this area.
  
  o MMC will improve patient satisfaction by evaluating and potentially implementing a hospitalist model.

- Conduct quality improvement for the project using methods such as rapid-cycle improvement.
  
  o Following the implementation of a hospitalist model, MMC will continue to improve the model and, ideally, further improve patient satisfaction, by conducting quality improvement activities.

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

We believe the need for this project could fall under several of the needs reported in the RHP #3 Community Needs Assessment list, but it best is categorized under CN.1 Inadequate access to primary care; CN2 Inadequate access to specialty care; CN6 Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly; and CN7 Insufficient access to care coordination practice management and integrated care treatment programs.

Currently, there is no hospitalist program at MMC. This project would be a new initiative to be implemented to raise patient satisfaction and improve patient outcomes with seamless transition from Emergency Department to inpatient services. Further, this access would eliminate delay in care. Because we have limited access to admitting physicians, often EMS will bypass the hospital to transport patients 30 miles away where physicians are available and on duty. Long term, the miles away from home and family are inconvenience to the patient and their recovery. We believe having access to needed care immediately will be beneficial to the patient and conducive to positive patient outcomes.

If a patient has a good experience, we believe they will continue to actively engage themselves in their future health related care which will ultimately lead to positive outcomes and lower overall healthcare costs. We are not aware of any related activities to this project that are funded by the US Department of Health and Human Services currently ongoing or coming up in the future.

Related Category 3 Outcome Measure(s):
OD-6 Percent improvement over baseline of patient satisfaction scores. The improvement targets in the related Category 3 outcome differ from the improvement measures identified in this project in that we propose addressing patient satisfaction by reducing the time for admission to inpatient services via the Emergency Department. T-Systems time studies will be used as the metrics for improvement on redesigning the patient experience through the ED to admissions.

We intend to use the HCAHPS survey to measure if our performance through implementing a Hospitalist Program has increased patient satisfaction. Obtaining patient feedback on our ability to provide the right care at the right time is critical to the success of this project and the internal operations of the clinic. This data will provide us with meaningful and objective information that will be used to determine whether our clinic has met patient expectations related to obtaining timely care and information, and will identify areas where we need to improve. Because the community we serve has an insufficient number of providers and patients are often unable to obtain appointments in a timely manner, the priority goal for this project is ensuring patients receive care when they need it and without significant delays, which will result in improved health outcomes and patient satisfaction. The HCAHPS survey is an effective tool for measuring our progress and will provide valuable information and feedback on our performance and areas where improvement is needed.

**Reasons/rationale for selecting the outcome measures:**

We believe if we can decrease patient anxiety and improve patient satisfaction in the rural setting when the patient is referred to the urban setting for extended/expanded healthcare that they will be more receptive and compliant to their healthcare needs which will ultimately lead to positive outcomes, improved patient satisfaction and ultimately lower healthcare costs. When patients perceive healthcare as a positive process, they will practice healthy lifestyles which results in lower healthcare costs.

We will focus on the stand-alone measure that will monitor an increase in patient satisfaction scores for the measure - patient is getting timely care, appointments, and information. We believe this measure is very important to the overall patient experience. These outcomes are important to our hospital because we believe if patients felt comfortable with the timeliness of their care, they would be less anxious about healthcare processes and more open to working with the healthcare providers. We believe by improving the patient experience through our Category 2 project – Hospitalist Model, the patient will feel optimistic about their healthcare experience and take care of themselves. Again, we believe by focusing on patient satisfaction for every patient, it will improve the health of low-income population as well as the total population.

**Relationship to other Projects:** 13790911 1.1 Hospital Based Clinic improving access to Primary and Specialty Care.

**Relationship to Other Performing Providers’ Projects in the RHP:** Innovation is key to the transformation of healthcare in our community. The consistency of innovation in our region allows for increased improvements based on research trends, patient need, and provider availability. The waiver funding allows for innovation in specific areas and all innovative projects included in the plan are similar in the fact of program redesigns for historic treatments, and focus to chronic condition outcome measures such as central line infections. The Region 3 initiative grid in the addendum can provide a side by side comparison of all projects that directly relate to innovation.
**Plan for Learning Collaborative:** We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region’s healthcare system.

**Project Valuation:**
We valued the project based on cost and benefits to our organization. We believe if we can reduce patient anxiety through access to the right care at the right place and in the right setting, the patient will have positive experiences and positive outcomes which will make them to want to take care of themselves by leading healthier lives, obtaining preventative healthcare and seeking medical help at appropriate times.

This project will target all residents of Calhoun County. The total inpatient impact is expected to be approximately 3000 patients via the Emergency Department. However, an average of 28,000 patients per year potentially could benefit by having a Hospitalist onsite for immediate patient care. Approximately 50% of patients are either Medicaid eligible or indigent, so we expect Medicaid and the uninsured will be beneficiaries of these services.

The valuation of each Memorial Medical Center project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, and the magnitude of costs avoided or reduced by the project. In particular, this project has been valued based on the logistical work required to change patterns of care in the inpatient setting, as well as the potential for quality improvement and patient experience improvement resulting from a successfully implemented hospitalist program.
**Evaluate Hospitalist Model**

| Milestone 1 | [P-7] Assess organizational baseline for measuring patient/family and/or employee experience and utilizing results in quality improvement. |
| Baseline/Goal: We will submit an assessment addressing the questions in the DSRIP menu |

| Milestone 3 | [P-11]: Orchestrate improvement work on identified experience targets. Workgroups should be formed under the steering committee to work on experience targets. Detailed implementation plans should be created for each workgroup. |
| Baseline/Goal: n/a |

| Milestone 4 | [P-X]: Engage stakeholders, identify resources and potential partnerships, and develop intervention plan including implementation of Hospitalist program and sustainability. |
| Metric 1 P-X.1: Cost Analysis of Hospitalist program |

| Milestone 5 | [P-16]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. |
| Metric 1 P-16.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in. |

| Milestone 6 | [I-20]: Redesign to improve patient experience by implementing a Hospitalist Program. |
| Metric 1 I-20 Decrease wait times from ED to inpatient admission to improve overall patient experience and expand access to care. |

| Milestone 7 | [P-16]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. |
| Metric 1 P-16.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in. |

| Milestone 8 | [I-20]: Redesign to improve patient experience by implementing a Hospitalist Program. |
| Metric 1 I-20 Decrease wait times from ED to inpatient admission to improve overall patient experience and expand access to care. |

| Milestone 9 | [P-16]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. |
| Metric 1 P-16.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in. |

| Milestone 10 | [I-20]: Redesign to improve patient experience by implementing a Hospitalist Program. |
| Metric 1 I-20 Decrease wait times from ED to inpatient admission to improve overall patient experience and expand access to care. |
the RHP to promote collaborative learning around shared or similar projects.

**Metric 1 P-16.1** Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in.

Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.

**Metric 2 P-16.2**: Share challenges and solutions successfully during this bi-weekly interaction.

Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.

**Milestone 2 Estimated Incentive Payment (maximum amount):**
$148,606

**Milestone 4 Estimated Incentive Payment (maximum amount):**
$183,786

**Milestone 6 Estimated Incentive Payment (maximum amount):**
$118,717

**Milestone 7 Estimated Incentive Payment (maximum amount):**
$183,786

**Milestone 9 Estimated Incentive Payment (maximum amount):**
$156,757

**Year 2 Estimated Milestone Bundle Amount: $297,212**

**Year 3 Estimated Milestone Bundle Amount: $356,153**

**Year 4 Estimated Milestone Bundle Amount: $367,573**

**Year 5 Estimated Milestone Bundle Amount: $313,514**

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**
(add milestone bundle amounts over Years 2-5): $1,334,452
Mental Health and Mental Retardation Authority of Harris County
Pass 2
2.15 INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES: 
COLLABORATIVE PRIMARY MEDICAL AND BEHAVIORAL HEALTH CARE

RHP Project Number: 113180703.2.1 
TPI: 113180703

Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

Intervention(s): MHMRA will design, implement, and evaluate a care management program that integrates primary and behavioral health care services.

Need for the project: There is a significant connection between mental health conditions and physical health. In 2011, about 68% of MHMRA patients reported having a medical condition, including hypertension, cardiovascular disease and diabetes. Psychiatric medications exacerbate the problem because they are associated with weight gain leading to obesity and high triglyceride levels, known risk factors for cardiovascular disease. Adults with serious mental illnesses are known to have poor nutrition, high rates of smoking, and a sedentary lifestyle—all factors that place them at greater risk for serious physical disorders, including diabetes, cardiovascular disease, stroke, arthritis and certain types of cancers. Despite such extensive medical needs, adults with serious mental illnesses often do not receive treatment for their chronic medical conditions.

Target population: MHMRA patients who are not already seen by a primary care physician. It is anticipated the program will provide service for about 1000 patients.

Category 1 or 2 expected patient benefits: MHMRA will

- Increase percent of individuals receiving both physical and behavioral health care at the established locations by 10% of baseline by DY5.
- Increase percent of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise by 5% over baseline by DY%.
- Increase the percentage of positive results of standardized health metrics

Category 3 outcomes: MHMRA expects to increase patient satisfaction with communication with providers and functional status by 10% from baseline by DY5.
2.15 Integrate primary and behavioral health care services: Collaborative Primary Medical and Behavioral Health Care

**RHP Project Number:** 113180703.2.1  
**Performing Provider/TPI:** Mental Health and Mental Retardation Authority of Harris County/113180703

**Project Description:**

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County will design, implement, and evaluate a care management program that integrates primary and behavioral health care services.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed, and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

MHMRA proposes a collaborative primary and behavioral health program to address the needs of patients with chronic physical and mental health problems. Over the past three decades, addressing both the physical and behavioral health needs of individuals has become an essential component of collaborative care delivery. In order to provide collaborative health care for the population served, MHMRA proposes to integrate primary care and behavioral health care services in eight locations in Harris County. Four primary care teams will be placed within four of the MHMRA’s mental health clinics; and four MHMRA mental health teams (consisting of psychiatrists, nurses, therapists, counselors, case managers, and rehabilitation clinicians) will be placed in public health/safety net facilities (e.g., FQHCs, public health clinics, Harris Health System outpatient clinics) to provide integrated primary and behavioral health care services.

The importance of this collaboration is to identify individuals who are being treated by the primary care clinic and are experiencing behavior health issues. Once identified, the mental health provider will be able to consult with the primary care provider regarding the patient’s care, provide psycho-education, provide assistance with the management of mental health and physical health issues, introduce self-management tools to improve the patient’s quality of life, and provide accessible follow-up at the same clinic site. Similarly, individuals being treated for mental health issues will be able to obtain physical health treatment. It is well documented that some of the medications taken by persons with severe and persistent mental illness often lead to or exacerbate metabolic syndrome disorders. The resulting co-morbid disorders of diabetes, high blood pressure, obesity, and asthma can be addressed by the primary care provider through the same methods of care as introduced by the behavior health provider. Cross collaboration between mental health providers and primary care physicians significantly improve patient outcomes.

It is expected that 800 patients can be seen by the four behavioral health and primary care provider teams by the end of DY2, followed by 400 each in DY3; 600 each in DY4; and 800...
Each by the end of DY5, for a total of 3,200 patients.

Both primary care and behavioral health patients are expected to show a 15% increase in the number of patients receiving both mental health and physical health treatment at the same location and a 25% improvement in care collaboration as evidenced by the collaboration between mental health providers and PCP on treatment plans. Also, the national average will be exceeded by 5% for cardiovascular and diabetes screening and monitoring for patients on antipsychotic and antidepressant medications.

**Goals and Relationship to Regional Goals:**
The overall goal of the proposed program is to improve mental health and medical treatment access for MHMRA patients via a collaborative treatment model. Specifically, there are several goals involving mental and physical health outcomes for the proposed program. For the patient, the goals are improved health outcomes (e.g., decreased blood pressure and blood sugar), more preventative screenings for early disease detection, increased health literacy, and increased adherence to medical treatment. Furthermore, goals related to mental health include improved adherence to psychiatric medications and treatment, earlier detection of relapses or non-compliance, improved medication adherence through better communication between different prescribers, and reduced side effects of psychotropic medications. Goals for the providers is a reduced no-show rate, increased collaboration between providers, improved patient input, making the patient a vested partner in improving health and behavioral health outcomes. Furthermore, both providers and the patient should see a reduction in costs through the collaborative efforts, the one-stop service provision, and the increased kept appointments.

**Regional Goals:**
Through the proposed program, MHMRA will address several areas of regional concern. The specific regional goal that will be addressed is increasing access to primary and specialty care services for underserved populations, which would ensure that patients receive the most appropriate care for their condition regardless of where they live or their ability to pay. This would help reduce the use of Emergency Centers as primary care providers for the seriously mentally ill.

**Challenges:**
The proposed implementation of collaborative teams faces several challenges, including patient issues, provider issues, and systemic problems. MHMRA patients are typically difficult to engage, have higher rates of mortality (compared to the general population), frequently demonstrate treatment compliance issues, have difficulties with follow-through, and lack resources; they are also a diverse population with numerous issues related to the management of their psychiatric conditions.

As a Performing Provider, MHMRA’s challenges in implementing a collaborative program include attracting providers, developing a collaborative environment, incentivizing patients to use the program, and engaging and educating patients to improve health literacy and health seeking behaviors.

Systemic issues will also present challenges to a collaborative approach. They include billing
complexities for two providers who may meet with a patient together, the high number of uninsured patients, limited access to primary care services resulting in subsequent over-utilization of ER for services, and systems for sharing health information with multiple care providers.

**Five-Year Expected Outcome:**
MHMRA hopes that at the end of the five-year DSRIP program, there will be notable improvements in patient-centered collaborations, improved medical and mental health outcomes for patients, and a significant reduction in ER services utilization by this population in the region due to improved access to primary care services. The attached milestones and metrics address yearly goals toward the five year outcomes.

**Starting Point/Baseline:**
Currently, a co-location program at El Centro De Corazon provides the opportunity to serve the medical needs of MHMRA patients who are also seen for psychiatric services in a mental health outpatient clinic. Current clinical space within the four locations will be assessed to determine if additional space will be needed to place the primary health care team. MHMRA hopes that local FQHC programs will have available space for the four proposed mental health teams; however, additional space within these programs may need to be leased.

**Rationale:**
In 2011, about 68% of MHMRA patients reported having a medical condition, 19% had hypertension and 7% had diabetes. While cardiovascular diseases (e.g., high blood pressure) are very prevalent amongst the mentally ill population, they are often undetected or untreated. Psychiatric medications exacerbate the problem because they are associated with weight gain, which leads to obesity and high triglyceride levels, known risk factors for cardiovascular disease. Adults with serious mental illnesses are known to have poor nutrition, high rates of smoking, and a sedentary lifestyle – factors placing them at greater risk for serious physical disorders such as diabetes, cardiovascular disease, stroke, arthritis and certain types of cancers. Despite such extensive medical needs, adults with serious mental illnesses often do not receive treatment for their chronic medical conditions. About 34% of MHMRA patients do not report having a PCP upon admission to mental health, and it is unknown how many who reported having a PCP actually maintain regular appointments for their chronic health care problems. Because of the high rates of medically indigent within MHMRA and Houston, we can assume few patients maintain regular follow-up. By improving mental health and medical treatment access for MHMRA patients via a collaborative treatment model, chronic conditions can be treated before the need for emergency treatment is required.

The concept of a medical home that can address these needs is key to improving access to care and continuity of care, which, in turn, would produce improved outcomes for patients. When coupled with protocols, training, technology, and team delivery models, co-location has the potential to improve communications between providers and to enhance the coordination of care. Coordination of care has been shown to provide improved medical care at significantly lower costs. Additionally, access to care is enhanced because individuals do not have to incur the cost or burden of arranging transportation. The ability to address both physical and behavioral health needs at a single facility reduces rates of disengagement and failure to follow through; this is
because customers would no longer need to plan and co-ordinate transportation to multiple locations for different services.

We have selected Category 2 metrics based on HEDIS behavioral health quality outcome measures for individuals with serious mental illnesses in 2013 (cf. Open Minds, 2012). These quality standards were field tested in 2012, followed by subsequent publication of national averages and ranges of scores. The standards require that individuals with schizophrenia or bipolar disorders receive an initial screening for diabetes and cardiovascular functioning, and that these individuals should continue to be monitored for these metabolic problems. Current metrics from both screening and monitoring have been set above the national baseline average levels reported in 2012 field trials.

To summarize, the rationale for the proposed program includes:
1) Improved patient physical and mental health care,
2) Reduced costs due to improved, collaborative and proactive care coordination and preventative care,
3) Increased consumer satisfaction due to ease of receiving services, and
4) Improved medical outcomes in a mental health population who are typically underserved.

**Project Components:**
In order to accomplish this integrated program, the following core components will be addressed:

a) MHMRA will identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community.
   • Both MHMRA clinics and FQHC locations will need to be identified and facility needs assessed
b) MHMRA will develop provider agreements to allow for co-scheduling and information sharing between physical health and behavioral health providers.
c) MHMRA will establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers.
d) MHMRA will recruit physical health providers to provide services in the designated locations.
e) MHMRA will train physical and behavioral health providers in protocols, effective communication and team approach. A shared culture of treatment will be fostered by MHMRA and will include specific protocols and methods of information sharing, specifically as follows:
   • Regular consultative meetings between physical health and behavioral health practitioners;
   • Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners; and/or
   • Shared treatment plans co-developed by both physical health and behavioral health practitioners.
MHMRA will provide home visitation as needed for assigned clinic patients to support care coordination and improve physical health and behavioral health outcomes.
f) MHMRA will acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated Electronic health
record system or participation in a health information exchange.
g) MHMRA will explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.
h) MHMRA will arrange for utilities and building services for these settings as is appropriate
i) MHMRA will develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.
j) MHMRA will conduct quality improvement for project using methods such as rapid cycle improvement.

Through these core components, MHMRA hopes to address the mental and physical health needs of our patients who are at high risk for metabolic syndromes related to chronic medical conditions and poor health practices, both of which can be exacerbated by the use of psychotropic medications. In addition, because MHMRA serves an economically disadvantaged population, many patients often go without medical care.

Unique Community Need Identification numbers:
In addition, the proposed project addresses community needs:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions
- CN10- High rates of preventable hospital admissions

The proposed program will meet several community needs by providing additional access to behavioral and physical health professionals. Furthermore, this service should help the community need to reduce reliance on ER services by engaging in more preventative care strategies.

Related Category 3 Outcome Measure(s):
IT-6.1 Percent improvement over baseline of patient satisfaction scores

Reasons/rationale for selecting the outcome measures:
Integration of primary and behavioral health care will provide the best opportunity to address the mental and physical health needs of our patients. Through collaboration and coordination of both behavioral and primary medical care, we aim to significantly impact patient satisfaction within the targeted population.

IT-10.1: Functional Status
We believe that our identified objective of transforming the current health care delivery system will be directly impacted by improving patient functioning. This transformation is proposed to be a patient-centered, coordinated delivery model that improves patient outcomes through better patient functioning. Based on this objective, the proposed program has identified the Adult Needs and Strengths Assessment (ANSA) to measure outcome improvement goals. ANSA is a
comprehensive assessment and outcome tool that measures patient strengths that can be used to build on for patient growth, as well as patient needs for purposes of treatment planning and delivery. We expect that there will be a 10% increase on at least one of the domains measured by the ANSA for patients in the program by DY5.

**Relationship to other Projects:**
Currently, this is the only program proposed by MHMRA that addresses collaborative care between physical and mental health providers. Additional programs may be proposed by the RHP. The cohabitation of primary care and behavioral health is an important focus of our region in order to treat the patient base with comprehensive physical and behavioral healthcare issues. There are multiple initiatives in our RHP plan which addresses this need, and all can be found on the Region 3 Initiative Grid in the addendums. The outcome measures focused to screening measures and access of the patient base.

**Plan for Learning Collaborative:**
In addition to participation in RHP collaborative programs we have included in the metrics and milestones, we will encourage collaboration between treatment providers in bi-weekly meetings.

**Project Valuation:**
In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document.

The following valuation is aligned with the demonstration program goals. These goals are to develop programs that enhance access to health care, increase the quality of care, provide the cost-effectiveness of care, and serve the health of the patients and families. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added.
The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature.

**Cost-Utility Analyses:** A review of the scientific literature identified several QALY-based estimates of the cost utility of providing collaborative mental health care in medical settings. One study examined collaborative care intervention for multi-symptom patients including depression, diabetes and coronary heart disease (Katon, Russo, Lin, Schmittiel, Ciechanowski, Ludman & Von Korff, 2012). According to the authors, there was a 0.335 QALYs gained.

A second study focused on treatment of major depression in the primary practice setting; they found a QALY gain of 0.049 (Rost, Pyne, Dickinson & LoSasso, 2005). In addition, Pyne, Smith, Fortney, Zhang, Williams, & Rost (2003) reported the cost utility of collaborative care for major depression. Their estimates yielded a 0.123 QALY gained over treatment as usual for females and an estimate of a slight, non-significant loss for males (-0.073 QALY).

An average increment across the three reports can be calculated as (0.335, 0.049, 0.123, and -0.073), which produces 0.1085 QALYs gained. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

\[
100 \text{ (persons served)} \\
0.1085 \text{ (QALY gained)} \\
\times 50,000 \text{ (life year value)} \\
= 542,500 \text{ QALY Value}
\]

**Cost-effectiveness and Cost Savings:** Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. We identified three such studies. The first two studies assessed cost savings attributed to “depression free days.” Rost and colleagues (2005) reported that a collaborative intervention for major depression produced a significant increment in days free of depression, resulting in 13.4 days between the first and second years of their study; whereas, Simon and colleagues (2012) reported a value of 47.7 depression-free days. Rost and colleagues also reported cost savings attributed to decreased medical costs. According to their findings, the intervention produced a savings of $777.20 (2012 dollars) per treated person. Assuming 100 people are served:

\[
100 \times 777.20 \text{ (health plan cost savings)} \\
= 77,720 \text{ Cost Savings: Health Costs}
\]

Similarly, Dewa et al. (2009) found that collaborative care saved $545 (2012 US Dollars) per patient in disability benefits. Additional value can be calculated as:

\[
100 \times 545 \text{ (disability benefit savings)} \\
= 54,500 \text{ Cost Savings: Disability}
\]
Summary and Total Valuation:
This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention. The total valuation is $542,500 per 100 patients served per year. Additional value in the form of depression-free days and reductions in disability payments are documented but not claimed.
<table>
<thead>
<tr>
<th>Unique Identifier: 113180703.2.1</th>
<th>RHP PP Reference Number: 2.15.1</th>
<th>Project Components: 2.15.1a - j</th>
<th>Program Title: COLLABORATIVE PRIMARY MEDICAL AND BEHAVIORAL HEALTH CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td></td>
<td></td>
<td>TPI: 113180703</td>
</tr>
<tr>
<td>Related Category 3 Measure(s):</td>
<td>113180703.3.8</td>
<td>IT-6.1</td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
</tr>
<tr>
<td>Function Status</td>
<td>113180703.3.30</td>
<td>IT-10.1</td>
<td>Improvement in functional status</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
</tr>
<tr>
<td>Milestone 1: P-2: Identify existing clinics or other community-based settings where integration could be supported.</td>
<td>Milestone 2 P-8 Participate in at least bi-weekly collaborative learning around shared or similar projects.</td>
<td>Milestone 4 [P-10]: Participate in bi-annual, face-to-face learning, &quot;raise the floor&quot; activities with other providers and the RHP.</td>
<td>Milestone 7 [I-8]: Integrated Services</td>
</tr>
<tr>
<td><strong>Metric 1: P-2.1</strong> discussions/ Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations.</td>
<td><strong>Metric 1 [P-8.1]</strong>: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.</td>
<td><strong>Metric 1 [P-10.1]</strong>: Participate in semi-annual face-to-face meetings and collaborate as described organized by the RHP.</td>
<td><strong>Metric 1 [I-8.1]</strong>: Percent of individuals receiving both physical and behavioral health care at the established locations.</td>
</tr>
<tr>
<td><strong>Goal:</strong> Identify sites for collaboration.</td>
<td><strong>Goal:</strong> Increase collaboration, share goals, progress, challenges and solutions</td>
<td><strong>Goal:</strong> Gain information from other programs that may assist current efforts, and improvements in process</td>
<td><strong>Goal:</strong> Increase integration by 15% of baseline</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Information from persons interviewed</td>
<td><strong>Data Source:</strong> Written documentation</td>
<td><strong>Data Source:</strong> Documentation of semiannual meetings including meeting</td>
<td><strong>Data Source:</strong> MHMRA records</td>
</tr>
<tr>
<td>Estimated Incentive Payment :</td>
<td>Estimated Incentive Payment :</td>
<td>Estimated Incentive Payment :</td>
<td>Estimated Incentive Payment :</td>
</tr>
<tr>
<td>$4,341,631.23</td>
<td>$2,386,412.62</td>
<td>$1,275,068.54</td>
<td>$1,642,600.37</td>
</tr>
<tr>
<td>Project Components: 2.15.1a - j</td>
<td>Project Components: 2.15.1a - j</td>
<td>Project Components: 2.15.1a - j</td>
<td>Project Components: 2.15.1a - j</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>RHP PP Reference Number: 2.15.1</td>
<td>RHP PP Reference Number: 2.15.1</td>
<td>RHP PP Reference Number: 2.15.1</td>
<td>RHP PP Reference Number: 2.15.1</td>
</tr>
<tr>
<td>Program Title: COLLABORATIVE PRIMARY MEDICAL AND BEHAVIORAL HEALTH CARE</td>
<td>Program Title: COLLABORATIVE PRIMARY MEDICAL AND BEHAVIORAL HEALTH CARE</td>
<td>Program Title: COLLABORATIVE PRIMARY MEDICAL AND BEHAVIORAL HEALTH CARE</td>
<td>Program Title: COLLABORATIVE PRIMARY MEDICAL AND BEHAVIORAL HEALTH CARE</td>
</tr>
<tr>
<td>Related Category 3 Measure(s):</td>
<td>Related Category 3 Measure(s):</td>
<td>Related Category 3 Measure(s):</td>
<td>Related Category 3 Measure(s):</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>Functional Status</td>
<td>IT-6.1</td>
<td>IT-10.1</td>
</tr>
<tr>
<td>113180703.3.8</td>
<td>113180703.3.30</td>
<td>IT-6.1</td>
<td>IT-10.1</td>
</tr>
<tr>
<td>TPI: 113180703</td>
<td>TPI: 113180703</td>
<td>TPI: 113180703</td>
<td>TPI: 113180703</td>
</tr>
<tr>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Milestone 3 [P-5]: Designate/hire personnel or teams to support and/or manage the project/intervention</td>
<td>Milestone 3 [P-5]: Designate/hire personnel or teams to support and/or manage the project/intervention</td>
<td>Milestone 3 [P-5]: Designate/hire personnel or teams to support and/or manage the project/intervention</td>
<td>Milestone 3 [P-5]: Designate/hire personnel or teams to support and/or manage the project/intervention</td>
</tr>
<tr>
<td>Metric 1 [P-5.1]: complete hiring for first team</td>
<td>Metric 1 [P-5.1]: complete hiring for first team</td>
<td>Metric 1 [P-5.1]: complete hiring for first team</td>
<td>Metric 1 [P-5.1]: complete hiring for first team</td>
</tr>
<tr>
<td>Goal: Identify number of staff needed and hire</td>
<td>Goal: Identify number of staff needed and hire</td>
<td>Goal: Identify number of staff needed and hire</td>
<td>Goal: Identify number of staff needed and hire</td>
</tr>
<tr>
<td>Data Source: personnel records</td>
<td>Data Source: personnel records</td>
<td>Data Source: personnel records</td>
<td>Data Source: personnel records</td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
</tr>
<tr>
<td>$2,386,412.62</td>
<td>$1,275,068.54</td>
<td>$1,642,600.37</td>
<td>$1,642,600.37</td>
</tr>
<tr>
<td>Milestone 5 [I-8]: Integrated Services</td>
<td>Milestone 5 [I-8]: Integrated Services</td>
<td>Milestone 5 [I-8]: Integrated Services</td>
<td>Milestone 5 [I-8]: Integrated Services</td>
</tr>
<tr>
<td>Metric 1 [I-8.1]: Percent of Individuals receiving both physical and behavioral health care at the established locations</td>
<td>Metric 1 [I-8.1]: Percent of Individuals receiving both physical and behavioral health care at the established locations</td>
<td>Metric 1 [I-8.1]: Percent of Individuals receiving both physical and behavioral health care at the established locations</td>
<td>Metric 1 [I-8.1]: Percent of Individuals receiving both physical and behavioral health care at the established locations</td>
</tr>
<tr>
<td>Numerator: total number of patients in clinic</td>
<td>Numerator: total number of patients in clinic</td>
<td>Numerator: total number of patients in clinic</td>
<td>Numerator: total number of patients in clinic</td>
</tr>
<tr>
<td>Denominator: number of patients receiving both physical and health care at location</td>
<td>Denominator: number of patients receiving both physical and health care at location</td>
<td>Denominator: number of patients receiving both physical and health care at location</td>
<td>Denominator: number of patients receiving both physical and health care at location</td>
</tr>
<tr>
<td>Goal: increase integration by 10% of baseline</td>
<td>Goal: increase integration by 10% of baseline</td>
<td>Goal: increase integration by 10% of baseline</td>
<td>Goal: increase integration by 10% of baseline</td>
</tr>
<tr>
<td>Data Source: Project data; claims and encounter data; medical records</td>
<td>Data Source: Project data; claims and encounter data; medical records</td>
<td>Data Source: Project data; claims and encounter data; medical records</td>
<td>Data Source: Project data; claims and encounter data; medical records</td>
</tr>
<tr>
<td>Milestone 8: I-9 Care Coordination</td>
<td>Milestone 8: I-9 Care Coordination</td>
<td>Milestone 8: I-9 Care Coordination</td>
<td>Milestone 8: I-9 Care Coordination</td>
</tr>
<tr>
<td>Metric 1: I-9.1: Individuals will report their collaboration with the provider on their treatment plan developed and implemented with primary care and behavioral health expertise</td>
<td>Metric 1: I-9.1: Individuals will report their collaboration with the provider on their treatment plan developed and implemented with primary care and behavioral health expertise</td>
<td>Metric 1: I-9.1: Individuals will report their collaboration with the provider on their treatment plan developed and implemented with primary care and behavioral health expertise</td>
<td>Metric 1: I-9.1: Individuals will report their collaboration with the provider on their treatment plan developed and implemented with primary care and behavioral health expertise</td>
</tr>
<tr>
<td>Numerator: total number of patients in clinic</td>
<td>Numerator: total number of patients in clinic</td>
<td>Numerator: total number of patients in clinic</td>
<td>Numerator: total number of patients in clinic</td>
</tr>
<tr>
<td>Denominator: number of patients reporting collaboration with both mh and pcp on treatment plan</td>
<td>Denominator: number of patients reporting collaboration with both mh and pcp on treatment plan</td>
<td>Denominator: number of patients reporting collaboration with both mh and pcp on treatment plan</td>
<td>Denominator: number of patients reporting collaboration with both mh and pcp on treatment plan</td>
</tr>
<tr>
<td>Goal: increase 25% over baseline</td>
<td>Goal: increase 25% over baseline</td>
<td>Goal: increase 25% over baseline</td>
<td>Goal: increase 25% over baseline</td>
</tr>
<tr>
<td>Related Category 3 Measure(s):</td>
<td>Project Components: 2.15.1a - j</td>
<td>Program Title: COLLABORATIVE PRIMARY MEDICAL AND BEHAVIORAL HEALTH CARE</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------</td>
<td>-------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>IT-6.1 IT-10.1</td>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td></td>
</tr>
<tr>
<td>Functional Status</td>
<td></td>
<td>TPI: 113180703</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td></td>
<td><strong>Year 3</strong></td>
<td></td>
</tr>
<tr>
<td>(10/1/2012 – 9/30/2013)</td>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 6: I-9** Care Coordination

**Metric 1: I-9.1** % of individuals who report their collaboration with the provider on their treatment plan developed and implemented with primary care and behavioral health expertise
Numerator: total number of patients in clinic
Denominator: number of patients reporting collaboration with both mh and pcp on treatment plan
Data source: Patient records
Goal: increase 10% over baseline

**Milestone 9: I-11** Positive Results of Standardized Health Metrics:

**Metric 1:** % of patients on antipsychotics who receive diabetes screening (HBA1c, fasting glucose, LDLC and triglycerides)
Denominator: number of patients assigned to clinic
Numerator: Number of patients who receive screening
**Goal:** 20% of patients will receive screening

**Metric 2:** % of patients on antipsychotics will receive cardiovascular screening (BP monitoring and BMI)
Denominator: number of patients assigned to clinic
Numerator: Number of patients who receive screening
**Goal:** 55% of patients will receive screening

**Metric 3:** % of patients with Schizophrenia and diabetes will receive diabetes monitoring (HBA1c and fasting glucose)
Denominator: number of patients assigned to clinic
<table>
<thead>
<tr>
<th>Year</th>
<th>Year</th>
<th>Year</th>
<th>Year</th>
</tr>
</thead>
</table>

**Related Category 3 Measure(s):**
- Patient Satisfaction
- Functional Status

**Program Title:**
COLLABORATIVE PRIMARY MEDICAL AND BEHAVIORAL HEALTH CARE

**RHP Performing Provider:** Mental Health and Mental Retardation Authority of Harris County

**TPI:** 113180703

**Percent improvement over baseline of patient satisfaction scores**
**Improvement in functional status**

**Numerator:** Number of patients who receive screening
**Goal:** 65% of patients will receive monitoring

**Metric 4:**
% of patients with Schizophrenia and cardiovascular health issues will receive cardiovascular monitoring (BP monitoring and BMI)

**Denominator:** Number of patients assigned to clinic
**Data source:** patient records

**Estimated Incentive Payment :**
- $1,275,068.54
- $1,642,600.37

**Milestone 7:** I-11 Positive Results of Standardized Health Metrics:
**Metric 1:** % of patients on antipsychotics who receive diabetes screening (HBA1c, fasting glucose, LDLC and triglycerides)

Denominator: number of patients assigned to clinic
<table>
<thead>
<tr>
<th>Year</th>
<th>Related Category 3 Measure(s):</th>
<th>Numerator</th>
<th>Goal</th>
<th>Metric</th>
<th>Denominator</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Patient Satisfaction</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Functional Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County

Program Title: COLLABORATIVE PRIMARY MEDICAL AND BEHAVIORAL HEALTH CARE

TPI: 113180703
<table>
<thead>
<tr>
<th>Year</th>
<th>Measure Description</th>
<th>Percent Improvement of Patient Satisfaction Scores</th>
<th>Improvement in Functional Status</th>
<th>Estimated Incentive Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
<td>-</td>
<td>-</td>
<td>$1,275,068.54</td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
<td>-</td>
<td>-</td>
<td>$4,341,631.23</td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
<td>-</td>
<td>-</td>
<td>$2,386,412.62</td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
<td>-</td>
<td>-</td>
<td>$1,275,068.54</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $19,142,531.77
References


2.13 PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING: INTEGRATING SUBSTANCE ABUSE TREATMENT SERVICES INTO MENTAL HEALTH SERVICES

RHP Project Number: 113180703.2.2  
TPI: 113180703

Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psychotherapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

Intervention(s): Substance abuse treatment services will be integrated and embedded into existing MHMRA mental health treatment services (psychosocial rehabilitation).

Need for the project: Presently, 31% of all MHMRA consumers have a documented substance abuse disorder, and the suspected number of individuals coping with substance abuse is much higher. National rates of comorbidity indicate that more than four million adults meet the criteria for both serious mental illness (SMI) and substance dependence and abuse (Office of Applied Studies, 2003b). According to the National Survey on Drug Use and Health (NSDUH) 23.2% of individuals with SMI were dependent or abused illicit drugs and alcohol compared to 8.2% of individuals without SMI.

Target population: MHMRA consumers with a co-morbid substance abuse diagnosis. It is anticipated the program will provide service for about 1900 patients by end of DY 5

Category 1 or 2 expected patient benefits: MHMRA will:

- decrease county jail bookings by 10% from baseline by DY5(I-1.1)
- decrease PES/HCPC admissions by 10% from baseline by DY5 (I-X.1)
- 5% decrease in the amount of illicit substances used as indicated by patient self-report during weekly monitoring by program staff.

Category 3 outcomes: MHMRA expects to increase patient satisfaction with communication with providers and functional status by 10% from baseline by DY5.
2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: Integrating substance abuse treatment services into mental health services

RHP Project Number: 113180703.2.2
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Project Description:
This Mental Health and Mental Retardation Authority (MHMRA) project will improve behavioral health care and reduce unnecessary use of emergency care by integrating substance abuse treatment services with existing mental health treatment services.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. The purpose of this project is to improve behavioral health and reduce unnecessary use of emergency psychiatric services by integrating substance abuse treatment services with existing mental health treatment services (psychosocial rehabilitation). The program will consist of assessment, individual therapy, group therapy, and will be embedded into existing treatment teams, consisting of licensed counselors, case workers, psychiatrists and psychologists.

MHMRA proposes to contract with a local entity for the services of 30 LCDCs who are experienced in working with patients who suffer from co-occurring disorders of mental illness and substance abuse. The goal is to begin the project by seeing 150 patients in DY2; 300 total in DY3; 800 in DY4; 800 more in DY5, with a grand total of 1900 patients seen by the end of DY5. The impact of these services will assist patients in decreasing their contact with the criminal justice system, psychiatric and medical inpatient services and will allow them to improve their level of functioning. It is expected that by DY5, patients will show a 10% decrease in jail bookings, and psychiatric admissions, a 30% increase in their level of functioning as measured by the ANSA, and a reduction in the use of illicit substances as measured by self-report and urinalysis.

Goals and Relationship to Regional Goals:
Program goals include reduction in psychiatric emergency services, reduction in jail bookings, reduction and/or cessation of drug and alcohol use, increased outpatient treatment participation, and increased mental health functioning. Additionally, consumer satisfaction will be assessed. These goals are compatible with the selected core components and the milestone and metrics addendum.

Regional goals:
It is important to note this project directly meets four broad goals identified by the region. First, it improves on existing programs and infrastructure by adding a component of treatment to
existing community mental health clinics. Second, it increases access to specialty care services by providing empirically based substance abuse treatment to individuals who otherwise, may not be able to afford this type of intervention. Next, the recovery model of substance abuse is inherently a patient-centered approach that moves away from the historical “disease” focused model of substance dependence. The proposed program will also complement the regional goal to develop a culture of “best practices” whereby the patient/consumer plays a more active role as a stakeholder by completing consumer satisfaction surveys. Finally, this program would provide empirically validated substance abuse treatment using national standards.

**Challenges:**
Patients with co-morbid disorders may be more reticent to engage in treatment and may have a higher early-termination rate than non-dually diagnosed consumers; MHMRA will utilize empirically based treatments, such as motivational interviewing to combat these challenges. In order to ameliorate any difficulties related to hiring staff, MHMRA plans to contract with the Houston Council on Alcohol and Drugs to provide this service inside the MHMRA Clinics.

**5 year expected outcome:**
The expected five-year outcome is to have a fully functioning, integrated substance abuse treatment program embedded in outpatient mental health services. It is expected that 1900 patients will have been treated in the program and will show improvement in their level of functioning, will decrease their contact with criminal justice and crisis services, and will report increased understanding of their co-occurring disorder. Measurement of outcomes will be done through the use of self reported substance use, urinalysis, the CAPHS, the ANSA, and jail contact data routinely collected by MHMRA.

**Starting Point/Baseline:**
Although MHMRA offers substance abuse treatment within the context of assertive community treatment, outpatient substance abuse treatment is virtually non-existent in other treatment programs. In order to accomplish this project, MHMRA plans to contract to hire 30 licensed clinical dependency counselors (LCDCs) to provide outpatient substance abuse treatment among existing MHMRA mental health clinics.

**Rationale:**
MHMRA of Harris County is an ideal agency to host this intervention given the rate of co-morbid drug and alcohol use among the severely mentally ill. Presently, 31% of all MHMRA consumers have a documented substance abuse disorder, and the suspected number of individuals coping with substance abuse is much higher. National rates of comorbidity indicate that more than four million adults meet the criteria for both serious mental illness (SMI) and substance dependence and abuse (Office of Applied Studies, 2003b). According to the National Survey on Drug Use and Health (NSDUH) 23.2% of individuals with SMI were dependent or abused illicit drugs and alcohol compared to 8.2% of individuals without SMI.

Not only is there a high base rate of co-occurring disorders in outpatient treatment, but the outpatient population accesses acute services at a higher rate. The Texas Health and Human Services Commission conducted a study in 2010 that examined inpatient admissions, mental health and substance abuse; results revealed that of those hospitalized for a mental health or substance abuse issue, 24% have a potentially preventable admission. Furthermore, this study
noted the increased rates of potentially preventable admission for any patient initially hospitalized for any issue if they have a co-morbid mental health or substance abuse diagnosis. Integration of treatment may provide an opportunity to identify more consumers who cope with substance abuse and mental illness and offer appropriate treatment. Additionally, it is hoped that integration will promote better outcomes and sustainable recovery among program participants. It is also expected that with preventative care, readmission rates to inpatient and psychiatric emergency services will be reduced.

**Project Components:**

In order to develop the proposed program the following core components (2.13) will be utilized:

a) Assess size, characteristics and needs of target population(s)

- Completed. MHMRA currently completes the Adult Texas Recommended Assessment (TRAG) to establish a treatment plan for each consumer. Section Seven of the TRAG addresses co-occurring substance abuse and clinicians are required to rate consumer on this index using a Likert scale (1-5; 5 is synonymous with drug dependence. This data is available in the current electronic medical record and charts
- Secondly, MHMRA clinicians and psychiatrists assess substance abuse disorders as part of their intake assessment. If a consumer meets criteria for drug abuse or dependence, they render an appropriate diagnosis.

b) Review literature / experience with populations similar to target population.

- To be completed. MHMRA will look to expert authorities within the agency and national resources, such as SAMHSA an NIDA prior to implementing specific treatment approaches or adopting specific manuals/materials.

c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.

- To be completed. MHMRA will develop a program evaluation that includes qualitative and quantitative metrics (e.g., pre/post assessment of program participants, use of psychiatric emergency services, jail bookings, patient satisfaction surveys, etc.)

d) Design models which include an appropriate range of community-based services and residential supports.

- To be completed. MHMRA currently offers residential treatment for individuals with co-morbid disorders. If this project is expanded, the agency will have community-based treatment as well. In addition, MHMRA will develop a toolkit that is interdisciplinary (mental health and substance abuse) and addresses key areas that impact the success of consumers. For example, consumers often need assistance with transportation, housing, and medical needs. MHMRA case workers and clinicians can address these needs using existing psycho-educational material.

e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.

- To be completed. MHMRA will work with the outcomes department to identify pre/post measures and patient satisfaction surveys that are empirically validated for individuals who are diagnosed with co-morbid conditions. See Category 3 Outcome for more details.
f) Community-based interventions should be comprehensive and multispecialty.
   - As mentioned above, this program will integrate substance abuse treatment services with existing mental health treatment services (psychosocial rehabilitation). Additionally, consumers will have access to nursing services and medication management.

**Milestones and Metrics:**
The program goals are consistent with the regional goals and community needs discussed above. Furthermore, the improvement metrics chosen to evaluate the performance of the program were specifically chosen to determine the impact the program will have on the patients receiving treatment and the community: (I-1, I-1.1 - 10% decrease in preventable admissions and readmissions into county jail bookings and I-X, I-X.1 - 10% decrease from baseline in PES/HCPC; I-X.1 10% reduction in substance use).

**Unique community need identification number the project addresses:**
In addition to the regional goal, the following community needs are addressed with the proposed program:

- CN3- Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

**Related Category 3 Outcome Measure(s):**
IT- 6.1 Percent improvement over baseline of patient satisfaction scores
IT-9.1 Functional Status

Through integrating substance abuse treatment services into mental health services we will increase enrollment and serve more individuals with co-morbid mental illness and substance abuse disorders. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes.

**Relationship to other Projects:**
This program would enhance other MHMRA DSRIP proposals, such as expansion of outpatient behavioral services.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

**Plan for Learning Collaborative:**
The project has no plans to establish a Learning Collaborative at this time but is open to doing so if another similar project is approved. Historically, MHMRA has worked informally and contractually with other providers in the community who are experts in substance abuse treatment, such as the Council on Drugs and Alcohol—Houston.

**Project Valuation:**

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

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

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per quality-adjusted life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this threshold. The number of life-years added is based on a review of the scientific literature.

**Cost-Utility Analysis:** One highly applicable cost utility study was identified that assessed the implementation motivational enhancement for substance abuse cessation. In 2001, Sellman, Sullivan, Dore, Adamson and MacEwan reported a randomized control trial for Motivational Enhancement Therapy (MET) for mild to moderate alcohol dependence. The study revealed that those who completed MET treatment (with mild to moderate dependence) showed a 0.116 QALY gain. These findings are relevant because MHMRA employees are trained in motivational interviewing techniques.

\[
\begin{align*}
100 \quad \text{(persons served)} \\
0.116 \quad \text{(QALY gained)} \\
\times \$50,000 \quad \text{(life year value)} \\
= \$580,000 \quad \text{QALY Value}
\end{align*}
\]

**Cost Effectiveness and Cost Savings:** Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. We identified one benefit-cost study that is related. As mentioned
previously, Mangrum and colleagues investigated the utility of integrated versus parallel treatment of co-occurring psychiatric and substance use disorders in Houston (2006). They reported an 8.9 percentage point decrease in the incidence of hospitalization for the integrated care treatment group. The parallel treatment group had a non-significant change in hospitalization. The cost savings per 100 persons treated associated with the avoidance of hospitalizations can be calculated as follows:

\[
\begin{align*}
&100 \text{ (persons treated)} \\
&0.089 \text{ (hospitalizations avoided)} \\
&10.25 \text{ (local average length of stay)} \\
&\times 700 \text{ (local cost per public psychiatric hospital bed day)} \\
&= 63,857.50 \text{ Total Hospital Costs Avoided}
\end{align*}
\]

These authors also reported a parallel reduction of 4.1% in jail events for their integrated treatment group. This group would have averted costs at the following rate:

\[
\begin{align*}
&100 \text{ (persons treated)} \\
&0.041 \text{ (bookings avoided)} \\
&40.5 \text{ (local average length of stay)} \\
&\times 130 \text{ (local cost per county jail bed day with mental health treatment)} \\
&= 21,586.50 \text{ Total Jail Costs Avoided}
\end{align*}
\]

**Summary and Total Valuation:** This valuation shows the proposed program will have a positive value for participants who receive the intervention(s). The combined QALY-based valuation ($580,000) plus psychiatric hospital cost avoidance ($63,857) plus jail cost avoidance ($21,586.50) valuation equals $685,444 per 100 treated persons served per year. Although further savings have been documented, only the QALY-based estimate of **$580,000 per 100 treated persons** is claimed. This concludes the valuation for the proposed project. The cited references for this section are included in the attached addendum.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1: P-2**: Design community-based specialized interventions. Design treatment program for co-morbid mental illness and substance abuse disorders.

**Metric 1: P-2.1** Project plans will be based on empirically based treatment approaches such as those proffered by NIDA and SAMHSA

**Data Source**: Written plan, project documentation

**Estimated Incentive Payment**: $4,177,569.59

**Estimated Incentive Payment**: $1,530,823.21

**Estimated Incentive Payment**: $981,508.98

**Estimated Incentive Payment**: $948,317.86

**N/A**

**Milestone 3: I-1**: Criminal justice admissions/readmissions - Jail Bookings

**Metric 1: I-1.1** Establish a baseline of criminal justice admissions among consumers with co-morbid mental illness and substance abuse.

**Data Source**: MHMRA and jail records.

**Estimated Incentive Payment**: $1,530,823.21

**Estimated Incentive Payment**: $981,508.98

**Estimated Incentive Payment**: $948,317.86

**N/A**

**Milestone 6: I-1**: Criminal justice admissions/readmissions - Jail Bookings

**Metric 1: I-1.1**: A 5% decrease from baseline in county jail bookings

**Data Source**: MHMRA and jail records.

**Estimated Incentive Payment**: $1,530,823.21

**Estimated Incentive Payment**: $981,508.98

**Estimated Incentive Payment**: $948,317.86

**N/A**

**Milestone 10: I-1**: Criminal justice admissions/readmissions - Jail Bookings

**Metric 1: I-1.1**: A 10% decrease from baseline in county jail bookings

**Data Source**: MHMRA and jail records.

**Estimated Incentive Payment**: $1,530,823.21

**Estimated Incentive Payment**: $981,508.98

**Estimated Incentive Payment**: $948,317.86
<table>
<thead>
<tr>
<th>Year</th>
<th>Milestone</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>N/A</td>
<td>Estimation of baseline for patient satisfaction scores.</td>
</tr>
<tr>
<td>Year 3</td>
<td>Milestone 4: I-X.4</td>
<td>Estimated Incentive Payment: $1,530,823.21</td>
</tr>
<tr>
<td>Year 4</td>
<td>Milestone 7: I-X.7</td>
<td>Estimated Incentive Payment: $981,508.98</td>
</tr>
<tr>
<td>Year 5</td>
<td>Milestone 8: I-X.8</td>
<td>Estimated Incentive Payment: $948,317.86</td>
</tr>
</tbody>
</table>

**Data Source:**
- PES records are part of the MHMRA electronic record.
- Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records.

**Metric 1:** I-X.1 A 5% decrease from baseline in PES/HCPC
a. Numerator: Percent of patients receiving Interim Care admitted to PES/HCPC during measurement period.
b. Denominator: The number of patients receiving Interim Care

**Metric 2:** I-X.2 A 5% reduction in the amount of illicit substances
a. Numerator: amount of substances used weekly
b. Denominator: weekly amount of substances reported at intake

**Metric 3:** I-X.3 10% decrease from baseline in PES/HCPC
a. Numerator: Percent of patients receiving Interim Care admitted to PES/HCPC during measurement period.
b. Denominator: The number of patients receiving Interim Care

**Metric 4:** I-X.4 5% decrease in the amount of illicit substances used as indicated by patient self-report during weekly monitoring by program staff.
a. Numerator: amount of substances used weekly
b. Denominator: weekly amount of substances reported at intake

**Metric 5:** I-X.5 5% reduction in the amount of illicit substances
a. Numerator: amount of substances used weekly
b. Denominator: weekly amount of substances reported at intake

**Metric 6:** I-X.6 Reduction in substance use.

**Metric 7:** I-X.7 Reduction in substance use.

**Metric 8:** I-X.8 Reduction in substance use.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
</tr>
<tr>
<td></td>
<td></td>
<td>used as measured by urinalysis at least every 90 days</td>
<td>used as measured by urinalysis at least every 90 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data Source: self-report, UA lab records</td>
<td>Data Source: self-report, UA lab records</td>
</tr>
<tr>
<td>$1,530,823.21</td>
<td>$981,508.98</td>
<td>$948,317.86</td>
<td>$948,317.86</td>
</tr>
<tr>
<td>$4,177,569.59</td>
<td>$4,592,469.64</td>
<td>$4,907,544.91</td>
<td>$4,741,589.28</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $18,419,173.42
REFERENCES


2.17 ESTABLISH IMPROVEMENTS IN CARE TRANSITION FROM THE INPATIENT SETTING FOR INDIVIDUALS WITH MENTAL HEALTH DISORDERS: REDESIGN OF THE TRANSITION FROM HCPC HOSPITALIZATION TO MHMRA OUTPATIENT AFTERCARE

RHP Project Number: 113180703.2.3  
TPI: 113180703

Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid.

Intervention(s): The HCPC transition program will hire licensed mental health professionals to engage patients pre-discharge from HCPC and assist with successfully linking them to community mental health treatment.

Need for the project: Only 49% of individuals discharged from HCPC attend an outpatient appointment within 30 days. Additionally, data analysis indicates that 5% of patients who are discharged from HCPC account for a significant proportion of readmissions to ER services.

Target population: Individuals being discharged from state psychiatric hospitals and the local, public psychiatric facility, Harris County Psychiatric Center (HCPC). It is anticipated the program will provide service for about 1375 patients.

Category 1 or 2 expected patient benefits: MHMRA will

- Demonstrate a 10% increase from baseline in warm handoffs by DY5
- Demonstrate a 5% increase in outpatient follow-up after HCPC discharge within 7 and 30 days from baseline.
- Demonstrate a 5% increase in target inpatient population members who have been discharged and have received clinician follow-up calls by end of DY5.

Category 3 outcomes: MHMRA expects to increase patient satisfaction with communication with providers (measured by CAPHS) and improvement in functional assessment (as measured by the ANSA) by 10% from baseline by DY5.
2.17 Establish improvements in care transition from the inpatient setting for individuals with mental health disorders: Redesign of the Transition from HCPC Hospitalization to MHMRA Outpatient Aftercare

Unique RHP Project Identification Number: 113180703.2.3

Performing Provider Name/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to establish improvements in care transition from the inpatient setting for individuals with mental health disorders by redesigning the transition from HCPC hospitalization to MHMRA outpatient aftercare.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. MHMRA is also responsible for providing outpatient aftercare services to individuals being discharged from state psychiatric hospitals and the local, public psychiatric facility, Harris County Psychiatric Center (HCPC), within 10 days of discharge. The objective of this new program is to improve the transition from HCPC to MHMRA community mental health outpatient treatment settings (2.17).

Goals and Relationship to Regional Goals:
The proposed program seeks to improve outpatient treatment adherence while decreasing subsequent readmission rates at HCPC. In order to decrease HCPC readmission, the program will assess the factors that are associated with low utilization of outpatient treatment after hospitalization and employ empirically based practices to increase utilization. For example, the program will employ “warm handoffs” or improved communication among treatment professionals across different treatment settings. Additional interventions will be assessed and prioritized following a literature review of empirically based approaches. Another emphasis of the program will be on improving patients’ involvement in discharge planning and outpatient treatment planning, using a person-centered approach. It is hoped that patients will be more likely to adhere to treatment plans if they are provided with more choices and autonomy in the treatment planning stage.

Challenges:
This project will examine barriers faced by individuals as they are discharged from HCPC inpatient care and referred to MHMRA for outpatient services. Influences of personal resources, attitudes about mental health and recovery, and the importance of ongoing care will be reviewed; strategies will then be designed to address each identified barrier, which may include
motivational interviewing, providing transportation or other material resources, and addressing patient choice.

5-Year Expected Outcome for Provider and Patients:

Our ultimate goal (e.g., five year goal), is that nearly all patients will attend outpatient mental health treatment within 30 days of discharge from HCPC to include MHMRA outpatient community option.

In order to enhance the transition from inpatient to develop such a program, the following option and core components were chosen: 2.17.1, Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health disorders. These components have also been imbedded in the program process and improvement milestones (See milestone and metric chart for further details). The status of each component is noted, if that activity is currently underway:

a. Develop a team comprised of clinical and administrative representatives from acute care, ambulatory care, behavioral health and community-based non-medical supports
   - To be developed. The proposed program will consist of two additional mental health professionals (LPHAs) who interface with HCPC staff and existing MHMRA programs to facilitate improved transitions to community based mental health treatment.

b. Conduct an analysis of the key drivers of 30-day hospital readmissions for behavioral health conditions using a chart review tool
   - In progress. The MHMRA Outcomes Management Department is reviewing hospital re-admission data for predictors of rapid readmission.

c. Identify baseline mental health and substance abuse conditions at high risk for readmissions, (example include schizophrenia, bipolar disorder, major depressive disorder, chemical dependency).
   - In progress. The MHMRA Outcomes Management Department recently completed an analysis of psychiatric emergency service use among existing consumers.

d. Review best practices for improving care transitions from a range of evidence-based or evidence-informed models
   - To be completed. A literature review will be conducted to identify and assess evidence-based practices to improve transitions from inpatient to community treatment.

e. Identify and prioritize evidence-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions.
   - To be completed. Following the literature review, administrators will review potential protocols and practices to improve transition.

f. Implement two or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population.
   - To be completed. Administration and management will select a pilot intervention and employ the strategy.

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

Starting Point/Baseline:
Patients who are admitted to inpatient treatment at HCPC are given an appointment at MHMRA’s outpatient clinics within 10- days of their discharge window. Patients are provided with an MHMRA appointment reminder form and the MHMRA crisis number should they need this prior to their MHMRA outpatient appointment. The patient also receives a reminder telephone call twenty-four (24) hours prior to the appointment and will receive follow up calls from the outpatient clinic if they fail to appear for services. Patients who are prescribed psychotropic medication are given five (5) days of medication with a prescription for a ten (10) day refill. It is well known that non-adherence to psychotropic medication is a key factor in relapse, and subsequently hospital readmission for individuals with severe mental illness.

The starting point for the 5 year improvement plan will be to increase the connect rate from the current approximately 50% to approximately 70% to mental health ongoing services. By increasing this connect rate, we want to improve the overall well being and satisfaction of our severely mentally ill population served in Harris County. We intend to do this through various techniques such as building patient relationships pre-discharge from hospitalization, strengthening mental illness and medication education, increasing engagement through home visits and phone contacts, and increasing overall patient satisfaction. We will monitor trends by cost analysis, case reviews, strengthening information technology sharing between systems, and expanding the role of our psychiatric teams with outreach. Our goal is to reduce admission rates, increase patient satisfaction, and decrease adverse risk to our high risk mentally ill population. We further intend to measure timely linkage of appointments and care with ongoing mental health services in addition to distribution of educational information to patients.

We anticipate serving about 1500 patients per DY year starting in DY 3 using the new program.

Rationale:
Until recently, all new patients were required to visit MHMRA’s Eligibility Center before obtaining an appointment at one of MHMRA’s outpatient clinics. In June of 2011, MHMRA amended the intake procedures for patients who were hospitalized at HCPC. Although the Eligibility Center is centrally located, having to be screened at the Eligibility Center post-hospitalization was conceptualized as a barrier to access to care. Because of this theory, the intake procedure was changed; HCPC patients were given follow-up appointments while in the hospital, without having to go to the Eligibility Center first. This change was made to improve the rate of outpatient treatment among recently discharged patients from HCPC. The rate of increase went from approximately 47% to 65% during this period of time and is currently at around 59%; we do not have figures on the connectivity rate after attempts to reengage by outpatient staff as a result of a missed initial appointment. The National Quality Forum and HEDIS averages are 43 and 42% respectively for seven (7) day aftercare appointments; 60% after thirty (30) days. Additionally, data analysis indicates that 5% of patients who are discharged from HCPC account for a significant proportion of readmissions.

It is hypothesized that linkage to outpatient treatment will increase due to implementation of this program. This theory is consistent with research conducted by Boyer, McAlpine, Pottick,
and Olfson (2000) using an inpatient psychiatric sample. They reported that three specific clinical interventions tripled the odds of successful linkage to outpatient care: communication about patients' discharge plans between inpatient staff and outpatient clinicians; patients' starting outpatient programs before discharge; and family involvement during the hospital stay.

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

This project directly meets broad goals identified by the regional needs assessment. First, it improves on existing programs. Second, it increases access to specialty care services by providing a novel treatment approach to a pervasive problem. The program also offers a preventative, patient-centered approach that provides individualized care to prospective outpatient consumers. The proposed program will also complement the regional need to develop a culture of “best practices” whereby the patient/consumer plays a more active role in treatment planning, and also by completing patient satisfaction surveys.

Redesign of the transition from HCPC hospitalization to MHMRA outpatient aftercare will address the following community needs:

- **CN3-Inadequate access to Behavioral Health**
- **CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly**
- **CN9- High rates of preventable hospital readmissions**

**Relationship to Other Projects:**

At this time there is not enough information available from the RHP to describe how this project may or may not be related to other RHP DSRIP proposals. However, this project will interface with the expansion of the collaborative primary medical and behavioral health care and expansion of outpatient treatment teams.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

The proposal will demonstrate a decrease in mental health symptoms and hospitalization for our patients by self report and data analysis. The mentally ill client experience and relationship with mental health professionals will increase through education, engagement, and intensive service provisions. We will measure patient satisfaction as well as timeliness of care, appointments and educational information sharing. Engaging this population with the personalized attention of checking on symptoms daily, providing transportation or bringing the treatment team to the individuals, working alongside the clients while in they are in hospitals to begin the relationship, and increasing the their understanding of their mental illness and medications, will ultimately improve the readmission rates to psychiatric hospitalization therefore decreasing the costs in our community.

**Related Category 3 Outcome Measure(s):**
IT-6.1: Percent improvement over baseline of patient satisfaction scores

We believe patient satisfaction that addresses patient involvement in improving care transition from an inpatient setting, will reduce chronic over-use of psychiatric emergency services and in general reduce cost and improve efficiency. By enhancing service linkage of outpatient behavioral health care we will address the community needs. Also providing greater access to behavioral health care and the addition of qualified behavioral health care professionals will allow for the provision of more services, great patient satisfaction and improved patient outcomes. We will be using the applicable parts of CAPHS to access this aspect of patient satisfaction and will be setting a target of 30% improvement in patient satisfaction by the end of Year 5.

IT-10.1: Functional Status

We believe that our identified objective of transforming the current health care delivery system will be directly impacted by improving patient functioning. This transformation is proposed to be a patient-centered, coordinated delivery model that improves patient outcomes through better patient functioning. Based on this objective, the proposed program has identified the ANSA (Adult Needs and Strengths Assessment), as a targeted means to measure outcome improvement goals. ANSA is a comprehensive assessment and outcome tool that measures both patient strengths that can be used to build on for patient growth and also patients needs for purposes of treatment planning and delivery. We expect that by DY5 there will be a 10% increase on at least one of the domains measured by the ANSA for patients in the program.

Plan for Learning Collaborative:

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

Project Valuation:

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

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

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention is a worthy value. The number of life-years added is based on a review of the scientific literature.

**Cost-Utility Analysis:** As mentioned above, QALYs represent relative improvements in quality of life years subsequent to a particular intervention. A thorough literature review revealed two studies that are relevant to the HCPC population. The first study, conducted by Chouinard and Albright (1997) provided a QALY gained of (0.125) when schizophrenic patients were treated with psychotropic medication (Risperdone) compared to those who received a placebo (-0.021). This study is relevant to the proposed population because individuals with schizophrenia represent a significant portion of MHMRA’s priority population, and many of the individuals who are discharged from HCPC do not have ongoing psychiatric care, making them similar to a waitlist or placebo control group. Using the QALY of 0.125, we can estimate a QALY value per 100 people:

\[
\begin{align*}
100 & \quad \text{(persons served)} \\
0.05 & \quad \text{(percent of high utilizers)} \\
0.125 & \quad \text{(QALY gained)} \\
$50,000 & \quad \text{(life year value)} \\
\text{} & \quad \text{QALY Value per 100} \\
$31,250 & \quad \text{(QALY Value per 100)}
\end{align*}
\]

**Cost Savings:** A second way to value this proposal is to assess cost avoidance. Dixon et al. (2009) assessed the effectiveness of a brief intervention to improve continuity of psychiatric outpatient care for patients who were discharged from inpatient psychiatric hospitals. Compared to the control group, the intervention group had significantly fewer days between their hospital discharge and their first outpatient appointment (3.5 days versus 15.0 days, p<0.001); were more likely to schedule their outpatient follow up (78% versus 38%, p<.001); to have kept their outpatient appointment 180 days post discharge (100% versus 86%, p<0.001). The intervention group had fewer hospitalizations (.2±.5 versus .6±1.0, \(\chi^2=4.14, \text{df}=1, p=.042\)) than the control group.

We can use the reduction of 40% between the control group and the intervention group to estimate cost savings relative to hospital admissions within the Houston area. Assuming the program serves 100 people, and 5% of the patients are at high risk of readmission as discussed in the program description, cost savings can be tallied. Using local data about HCPC costs and average length of stay among MHMRA consumers, the following cost savings is proposed:

\[
\begin{align*}
100 & \quad \text{(persons served)} \\
0.05 & \quad \text{(percent of high utilizers)} \\
0.40 & \quad \text{(reduced hospitalizations)} \\
10.25 & \quad \text{(average length of stay)} \\
x & \quad \text{(average cost per diem)} \\
$700 & \quad \text{(average cost per diem)} \\
\text{} & \quad \text{Cost Savings} \\
$14,350 & \quad \text{Cost Savings}
\end{align*}
\]
**Summary and Total Valuation:** This valuation analysis shows that the intervention will have a positive value for participants. The combined estimates of $31,250 QALY gained and $14,350 Cost Savings yield a total valuation of $45,600 per 100 people served per year. It is hoped the proposed program could benefit 1,375 people per year, for a valuation of $627,000 per 1,375 people served per year. This concludes the valuation for the proposed project. The cited references for this section are included in the attached addendum.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1: P-28:</strong> Gap analysis regarding patient communication with providers and/or discharge information</td>
<td><strong>Milestone 4: P-4:</strong> Hire 2 clinicians with care transition expertise</td>
<td><strong>Milestone 7: I-31:</strong> Warm Handoffs from inpatient to outpatient.</td>
<td><strong>Milestone 11: I-31:</strong> Warm Handoffs.</td>
</tr>
<tr>
<td>Estimated Incentive Payment: $167,262.85</td>
<td>Estimated Incentive Payment: $183,874.74</td>
<td>Estimated Incentive Payment: $294,734.74</td>
<td>Estimated Incentive Payment: $284,767.86</td>
</tr>
</tbody>
</table>

**Milestone 2: P-2.** Collect and analyze data on factors contributing to readmissions to HCPC within 30 days of discharge

**Metric 2: P-2.7** Identification of key factors that increase the likelihood of preventable 30 day readmissions for individuals with mental health disorders

**Data Sources:** Report on readmission data

Estimated Incentive Payment: $167,262.84

**Milestone 3:** P-8. Pilot test intervention approaches at HCPC sites

**Metric 5: P-8.1** Implementation of evidence-based interventions on a pilot inpatient unit, including number of patients served

**Data Sources:** Detailed implementation plan; program records

Estimated Incentive Payment: $183,874.75

**Milestone 5:** P-42. Follow-up after Hospitalization

**Metric 8: P-42.1** Baseline for patients receiving Follow-Up After HCPC discharge within 7 and 30 days (NQF#-576)

- a. Numerator: Number of patients who were hospitalized at HCPC then went to outpatient appt. visit 7-30 days after discharge.
- b. Denominator: Number of patients discharged from HCPC

**Data Source:** MHMRA records

Goal: Establish baseline

Estimated Incentive Payment: $294,734.74

**Milestone 8:** P-42. Follow-up after Hospitalization

**Metric 12:** P-42.1 Outpatient Follow-Up After HCPC discharge within 7 and 30 days

**Data Source:** MHMRA and HCPC Records

Goal: 5% increase from baseline

Estimated Incentive Payment: $284,767.86
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 3: P-6: Identify evidence-based frameworks that support seamless care transitions and impact preventable 30-day readmissions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 3: P-6.1. Selection of an evidence based framework</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Meeting minutes displaying the selection of evidence based framework</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 6: I-31. Warm Handoffs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 6. I-31.1 Measure baseline of the use of warm handoffs for adult inpatients being discharged to the community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: MHMRA clinical records and HCPC records. Percent of people who received warm handoffs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Measure baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 9: I-30. Enrollment in Community Based Support Program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 9: I-30.1. 5% increase the number of high risk patients enrolled in community based support programs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Numerator: number of high-risk patients in the RHP Project Sites who were enrolled in community support programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Denominator: number of high-risk patients in the RHP Project Sites</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Data Source: Documented, implemented support plans approved by transition / service team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Establish base line</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 13: I-30. Enrollment in Community Based Support Program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 13: I-30.1. 5% increase the number of high risk patients enrolled in community based support programs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: 5% increase from baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estimated Incentive Payment: $167,262.84</th>
<th>Estimated Incentive Payment:$183,874.74</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Milestone 10: I-40: Assessment and Follow-up</td>
<td></td>
</tr>
<tr>
<td>Metric 10- I-40: 5% increase in target inpatient population members who have been discharged and have received clinician follow-up calls to review treatment plans and assess compliance.</td>
<td></td>
</tr>
<tr>
<td>a. Numerator: The number of patients in the target population discharged from inpatient settings who have</td>
<td></td>
</tr>
<tr>
<td>Milestone 14: I-40: Assessment and Follow-up</td>
<td></td>
</tr>
<tr>
<td>Metric 14- I-40: 5% increase in target inpatient population members who have been discharged and have received clinician follow-up calls to review treatment plans and assess compliance.</td>
<td></td>
</tr>
<tr>
<td>Goal: 5% increase from baseline.</td>
<td></td>
</tr>
<tr>
<td>Unique Identifier: 113180703.2.3</td>
<td>2.17.1</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------</td>
</tr>
</tbody>
</table>

Mental Health and Mental Retardation Authority of Harris County

<table>
<thead>
<tr>
<th>Related Category 3 Measure(s): 113180703.3.10</th>
<th>IT-6.1</th>
<th>IT-9.1</th>
<th>Percent improvement over baseline of patient satisfaction scores Functional Assessment</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Goal: establish baseline.</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

- Denominator: The number of patients in the target population discharged from inpatient settings
- Data Source: Medical Records; Project Data; Clinician Logs.

Year 2 received follow-up contact (two attempts) to review treatment plans and assess compliance.

- Estimated Incentive Payment: $167,262.84
- Estimated Incentive Payment: $183,874.75
- Estimated Incentive Payment: $294,734.74
- Estimated Incentive Payment: $284,767.86

Year 2 Estimated Outcome Amount: $501,788.53
Year 3 Estimated Outcome Amount: $551,624.23
Year 4 Estimated Outcome Amount: $589,469.48
Year 5 Estimated Outcome Amount: $569,535.72

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $2,212,417.96
REFERENCES


2.13 PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING: EXPAND CHRONIC CONSUMER STABILIZATION INITIATIVE

RHP Project Number: 113180703.2.4

Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid.

Intervention(s): MHMRA plans to expand the Chronic Consumer Stabilization Initiative (CCSI), an interagency collaboration with the Houston Police Department (HPD). Staff members provide intensive case management and work directly with individuals, family members, health providers, and/or staff at living facilities. MHMRA provides family and community education about mental illness, outreach and engagement, intensive case management, Mental Health First Aide (an evidence-based mental health awareness program for community members), navigation to address physical health, housing and other social needs, crisis intervention and advocacy typically for several months, longer than other crisis diversion programs.

Need for the project: There are at least 70 more individuals that have been identified who meet the target population than can be served within the current capacity of the program.

Target population: The program will target individuals who have been diagnosed with a serious and persistent mental illness, have frequent admissions to emergency and crisis services, and have frequent encounters with HPD. It is anticipated that the program will provide services for about 60 patients.

Category 1 or 2 expected patient benefits: MHMRA will:

- Enroll 10 additional individuals yearly starting in DY 3 who chronically access PES services.
- Reduce emergency detention orders, law enforcement calls for service, arrests, and jail by 10% decrease from baseline by DY5
- Reduce PES/HCPC admissions by 10% decrease from baseline by DY5.

Category 3 outcomes: MHMRA expects to increase patient satisfaction with communication with providers and improvement in functional assessment by 10% from baseline by DY5.
2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: Expand chronic consumer stabilization initiative

Unique RHP Project Identification Number: 113180703.2.4

Performing Provider Name/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting by expanding a chronic consumer stabilization initiative.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed, and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. MHMRA seeks to expand the Chronic Consumer Stabilization Initiative (CCSI), an interagency collaboration with the Houston Police Department (HPD). The purpose of this project is to improve behavioral health and reduce unnecessary use of emergency psychiatric services by identifying individuals who are frequent users of psychiatric emergency services (PES) and police.

Goals and Relationship to Regional Goals:
The primary goal of the program is to identify, engage and provide services to individuals who have been diagnosed with a serious and persistent mental illness, have frequent admissions to emergency and crisis services, and have frequent encounters with HPD either through their own initiative or by family and/or collateral contact. Staff members provide intensive case management and work directly with individuals, family members, health providers, and/or staff at living facilities. Familial and community education about mental illness is a key component. CCSI provides outreach and engagement; intensive case management; Mental Health First Aid (an evidence-based mental health awareness program for community members); navigation to address physical health, housing and other social needs; crisis intervention, and advocacy. It is also important to note the length of stay for individuals open to CCSI is several months, compared to other crisis diversion services in the area.

The goals of this project are to avert outcomes such as potentially avoidable inpatient admission and readmissions in settings such as general acute and specialty (psychiatric) hospitals; to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to medication and other treatments; and to promote recovery in the community. This can be done by providing community-based interventions for individuals to prevent them from cycling through multiple systems such as the criminal justice system, general acute and specialty psychiatric inpatient system; and mental health system.
Expected 5-year Outcomes: The five-year goals of this project are to expand capacity in the program from 30 to 60 individuals and to reduce the number of law enforcement interactions, psychiatric crisis interventions, and psychiatric hospital admission for this cohort.

Challenges: Challenges to implementation include motivating these individuals to accept and engage in care and providing adequate education and information to family members and/or staff at their living facilities. These challenges will be addressed through intensive engagement activities, motivational interviewing, providing education, and collaborating with law enforcement to divert the participants away from intensive crisis services.

Starting Point/Baseline: CCSI is an existing MHMRA program that serves 30 individuals. The proposed project will expand the number of individuals served to 60 by DY5.

Rationale: There is a cohort of individuals within the region who have been identified by HPD as having multiple involuntary admissions to psychiatric emergency services because they were brought in by law enforcement personnel. MHMRA and Houston Police Department have collaborated in a project to provide specialized interventions for 30 of these individuals. However, at least 70 more individuals have been identified who meet the target population than can be served within the current capacity of the program.

Outcomes from the existing program reveal a significant reduction in criminal justice involvement and in psychiatric emergency care and hospitalizations. If this program averted only one PES service per patient per year, the savings would be more than $7,000 per patient ($700 per bed x 10.25 average length of stay in Harris County public psychiatric hospital). Because many of these individuals have multiple admissions per year, the savings would be considerably higher. For example, data from the existing program revealed a 28% decrease in psychiatric emergency services and public psychiatric hospitalizations among existing CCSI consumers (MHMRA, 2010: Pilot Project Final Report). Additionally, all patients have a right to be served in the least restrictive environment possible. Lastly, the program has met with much success and has received recognition nationally, including nominations for Herman Goldstein Problem Oriented Policing award and an International Chiefs of Police Award.

Project Components:

a) Assess size, characteristics and needs of target population(s)
   - In progress. MHMRA and the Houston police department are continuously compiling a list of potential consumers who would benefit from the program. Demographic data, criminal justice involvement, and psychiatric emergency services are also gathered to better understand the needs of this population. MHMRA and HPD will continue to conduct this analysis as needed.

b) Review literature / experience with populations similar to target population.
• To be completed. MHMRA will look to expert authorities and national resources, such as SAMHSA, prior to implementing specific treatment approaches or adopting specific manuals/materials.

c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.
  • To be completed. MHMRA will develop a program evaluation that includes qualitative and quantitative metrics (e.g., pre/post assessment of program participants, use of psychiatric emergency services, jail bookings, patient satisfaction surveys, etc.)

d) Design models which include an appropriate range of community-based services and residential supports.
  • To be completed. MHMRA consumers often need assistance with transportation, housing, and medical needs. MHMRA clinicians can address these needs using existing psychoeducational material. Additionally, MHMRA has a residential step-down program that may be used by CCSI consumers if they need transitional housing post-hospitalization before returning to the community.

e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.
  • To be completed. MHMRA will work with the outcomes department to identify pre/post measures and patient satisfaction surveys that are empirically validated for individuals who are diagnosed with co-morbid conditions. See Category 3 Outcome for more details.

f) Community-based interventions should be comprehensive and multispecialty.
  • As mentioned above, this program is inherently multidisciplinary and uses resources provided both by the local mental health authority and the local police.

**Milestones and Metrics:**
The goals are consistent with the regional goals and community needs discussed above. Furthermore, the improvement metrics chosen for this project (I-10.1: % decrease in emergency detention orders, law enforcement calls for service, arrests, and jail, and I-X.1: % decrease from baseline in PES/HCPC) will determine the progress MHMRA is making to meet our stated goals. Both measure the success in reducing the use of jail services and ER services through the proposed program.

**Relationship to other Projects:** At this time there is not enough information available from the RHP to describe how this project may or may not be related to other RHP DSRIP proposals. However, the proposed project is similar to several MHMRA DSRIP proposals, including the expansion of the Crisis Residential Unit, expansion of the Interim Care Clinic, and redesign of the transition from HCPC hospitalization to MHMRA outpatient aftercare. All three proposals seek to expand psychiatric stabilization while reducing inpatient admissions and criminal justice involvement. It is hoped that many of the CCSI patients could access these less restrictive and more appropriate care levels in lieu of hospitalization or civil commitment.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus
to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

**Unique community need identification number the project addresses:**
This project directly meets broad goals identified by the regional needs assessment. First, it improves on existing programs and infrastructure by adding a component of treatment to existing community mental health service array. Second, it increases access to specialty care services by providing treatment to individuals who otherwise, may not be able to afford this type of intervention. Finally, this program is inherently a patient-centered approach that moves away from the historical “disease” focused model of repeated hospitalizations. The proposed program will also complement the regional need to develop a culture of “best practices,” whereby the patient/consumer plays a more active role as a stakeholder by completing consumer satisfaction surveys.

CCSI addresses the following community needs:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

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

**Project Valuation:**
In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature.

**Cost-Utility Analysis:**
A literature reviewed one QALY that is highly relevant to this population. This 2012 study reported the QALY gains associated of assertive community treatment (ACT) compared to standard case management care in patients with schizophrenia (Karow, Reimer, König, Heider, Bock & Huber ...2012). ACT is highly similar to the proposed intervention in that it seeks to identify high utilizers of psychiatric emergency services and provide intensive case management to reduce psychiatric inpatient admissions and jail detentions. According to the Karow et al. study, the ACT intervention yielded a QALY of 0.76, whereas the treatment as usual group resulted in a QALY of 0.66; therefore, the incremental QALY for the ACT group was 0.10.

Applying this estimate to the current population the value of enhancing services for these underserved individuals from Level Four can be calculated as follows:

\[
60 \text{ (persons served)} \times 0.10 \text{ (QALY gained)} \times $50,000 \text{ (life year value)} = $300,000 \text{ Level 4 QALY Value}
\]

**Cost Savings:**
In addition to quality of life years adjusted, we obtained local data that supports the notion that ongoing treatment in the form of medication management and case management reduces hospital admissions. Specifically, individuals who are deemed “psychiatrically underserved” in Harris County require higher levels of public psychiatric hospital care. (Underserved means individuals received less services than their treatment plan and history indicates is necessary for recovery from mental illness.) In a sample of 6,275 consumers studied over seven years, underserved MHMRA consumers logged 0.819 additional hospital bed days per year. The increment in costs that could be averted with these interventions can be calculated as:

\[
60 \text{ (persons served)} \times 0.819 \text{ (psychiatric bed days gained)} \times $700 \text{ (local bed day value)}
\]
Summary and Total Valuation:
This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). The expected value of this proposal is $334,398 ($300,000 and $34,398) per 60 people served per year. (If 100 people were served per year, the estimated savings would be $557,330). Additional cost savings in the form of diverted jail detentions is also expected.
<table>
<thead>
<tr>
<th>Related Category 3 Measure(s):</th>
<th>Unique Category 3 Project ID:</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
<th>Improvement in Functional Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction</td>
<td>IT-6.1</td>
<td>IT-10.1</td>
<td></td>
</tr>
<tr>
<td>Functional Status</td>
<td>113180703.3.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>113180703.3.33</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Chronic consumer stabilization initiative**

**Mental Health and Mental Retardation Authority of Harris County**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1:** P-2. Refine treatment program to provide empirically based services to chronic Psychiatric Emergency Service (PES) and Criminal Justice (CJ) users

**Metric 1:** P-2.1
Project plans will be based on empirically based treatment approaches such as those proffered by SAMHSA

**Data Source:** Written plan

<table>
<thead>
<tr>
<th>Milestone 2:</th>
<th>P-3. Identify and enroll individuals who are chronic PES/CJ users</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1:</strong> P-3.1</td>
<td></td>
</tr>
<tr>
<td>Enroll 10 individuals who chronically access PES services (from baseline of 30, 40 people will be served)</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project documentation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 3:</th>
<th>P-3. Enroll and serve individuals who are chronic PES/CJ users</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1:</strong> P-3.1</td>
<td></td>
</tr>
<tr>
<td>Enroll 10 more individuals who chronically access PES services (from baseline of 30, 50 people will be served)</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project documentation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 4:</th>
<th>Enroll and serve individuals who are chronic PES/CJ users</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1:</strong> P-3.1</td>
<td></td>
</tr>
<tr>
<td>Enroll 10 more individuals who chronically access PES services (from baseline of 30, 60 people will be served)</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project documentation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 5:</th>
<th>Enroll and serve individuals who are chronic PES/CJ users</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1:</strong> P-3.1</td>
<td></td>
</tr>
<tr>
<td>Enroll 10 more individuals who chronically access PES services (from baseline of 30, 60 people will be served)</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project documentation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 6:</th>
<th>Enroll and serve individuals who are chronic PES/CJ users</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1:</strong> P-3.1</td>
<td></td>
</tr>
<tr>
<td>Enroll 10 more individuals who chronically access PES services (from baseline of 30, 60 people will be served)</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project documentation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 7:</th>
<th>Enroll and serve individuals who are chronic PES/CJ users</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1:</strong> P-3.1</td>
<td></td>
</tr>
<tr>
<td>Enroll 10 more individuals who chronically access PES services (from baseline of 30, 60 people will be served)</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project documentation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 8:</th>
<th>Enroll and serve individuals who are chronic PES/CJ users</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1:</strong> P-3.1</td>
<td></td>
</tr>
<tr>
<td>Enroll 10 more individuals who chronically access PES services (from baseline of 30, 60 people will be served)</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project documentation</td>
<td></td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>$267,618.95</td>
<td>$98,065.94</td>
<td>$104,793.94</td>
<td>$101,250.19</td>
</tr>
<tr>
<td>Related Category 3 Measure(s):</td>
<td>Unique Category 3 Project ID:</td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
<td>Improvement in Functional Status</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>IT-6.1</td>
<td>IT-10.1</td>
<td></td>
</tr>
<tr>
<td>Functional Status</td>
<td>113180703.3.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>113180703.3.33</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
<tr>
<td>N/A</td>
<td>Milestone 3: I-10. Law Enforcement Interactions</td>
<td>Milestone 6: I-10. Law Enforcement Interactions</td>
<td>Milestone 9 I-10. Law Enforcement Interactions</td>
</tr>
<tr>
<td></td>
<td>Metric 3: I-10.1 % decrease in emergency detention orders, law enforcement calls for service, arrests, and jail bookings/admission</td>
<td>Metric 1: I-10.1 % decrease in emergency detention orders, law enforcement calls for service, arrests, and jail bookings/admission</td>
<td>Metric 1: I-10.1 % decrease in emergency detention orders, law enforcement calls for service, arrests, and jail bookings/admission</td>
</tr>
<tr>
<td></td>
<td>a. Numerator: Percent of individuals receiving CCSI who have emergency detention orders, law enforcement calls for service, arrests, and jail bookings/admission during measurement period.</td>
<td>a. Numerator: Percent of individuals receiving CCSI who have emergency detention orders, law enforcement calls for service, arrests, and jail bookings/admission during measurement period.</td>
<td>a. Numerator: Percent of individuals receiving CCSI who have emergency detention orders, law enforcement calls for service, arrests, and jail bookings/admission during measurement period.</td>
</tr>
<tr>
<td></td>
<td>b. Denominator: The number of individuals receiving CCSI Data Source: Harris County Police Department Records, County Jail, and MHMRA records</td>
<td>b. Denominator: The number of individuals receiving CCSI Data Source: Harris County Police Department Records, County Jail, and MHMRA records</td>
<td>b. Denominator: The number of individuals receiving CCSI Data Source: Harris County Police Department Records, County Jail, and MHMRA records</td>
</tr>
<tr>
<td></td>
<td>Goal: establish baseline for patients served in DY 3</td>
<td>Goal: 5% decrease from baseline in emergency detention orders, law enforcement calls for service, arrests, and jail bookings/admission</td>
<td>Goal: 10% decrease from baseline in emergency detention orders, law enforcement calls for service, arrests, and jail bookings/admission</td>
</tr>
<tr>
<td>N/A</td>
<td>Estimated Incentive Payment: $98,065.94</td>
<td>Estimated Incentive Payment: $104,793.95</td>
<td>Estimated Incentive Payment: $101,250.19</td>
</tr>
</tbody>
</table>
### Chronic consumer stabilization initiative

**Mental Health and Mental Retardation Authority of Harris County**

<table>
<thead>
<tr>
<th>Related Category 3 Measure(s):</th>
<th>Unique Category 3 Project ID:</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
<th>Improvement in Functional Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction</td>
<td>IT-6.1</td>
<td>IT-10.1</td>
<td></td>
</tr>
<tr>
<td>Functional Status</td>
<td>113180703.3.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>113180703.3.33</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Year 2</strong></th>
<th><strong>Year 3</strong></th>
<th><strong>Year 4</strong></th>
<th><strong>Year 5</strong></th>
</tr>
</thead>
</table>

#### Milestone 4: I-X. Psychiatric Emergency Service (PES) Readmissions and Inpatient Public Hospital Admissions

**Metric 1:** I-X.1. Establish a baseline of CCSI consumers’ HCPC/inpatient admissions.

**Data Source:** PES records are part of the MHMRA electronic record. Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records.

#### Milestone 7: I-X. Psychiatric Emergency Service (PES) Readmissions and Inpatient Public Hospital Admissions

**Metric 1:** I-X.1

A % decrease from baseline in inpatient hospital admits (HCPC)

- **Numerator:** Percent of patients receiving CCSI services admitted to PES/HCPC during measurement period.
- **Denominator:** The number of patients receiving CCSI services

**Data Source:** MHMRA and HCPC records

**Goal:** reduce admissions to HCPC by 5%

<table>
<thead>
<tr>
<th><strong>Estimated Incentive Payment:</strong></th>
<th><strong>Estimated Incentive Payment:</strong></th>
<th><strong>Estimated Incentive Payment:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$98,065.95</td>
<td>$104,793.95</td>
<td>$101,250.19</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Milestone Bundle Amount: $267,618.95 | Year 3 Estimated Milestone Bundle Amount: $294,197.83 | Year 4 Estimated Milestone Bundle Amount: $314,381.84 | Year 5 Estimated Milestone Bundle Amount: $303,750.57 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,179,949.19
2.13 PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING: EXPANSION OF MOBILE CRISIS OUTREACH TEAM

RHP Project Number: 113180703.2.5  
TPI: 113180703

Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid.

Intervention(s): MHMRA proposes to expand the current Mobile Crisis Outreach Team (MCOT), which provides mobile crisis outreach and follow-up to adults and children who are unable or unwilling to access traditional psychiatric services. When a consumer initiates an MCOT intervention, two trained MCOT staff respond to the consumer’s needs, meeting them in a variety of settings including in the consumer’s community, home, or school and provide assessment, intervention, education, and linkage to other services to address identified needs.

Need for the project: MCOT has grown by more than 52% since inception in 2004, from 1,224 episodes of care to 1,861 episodes in 2011. The program reached its current peak capacity in 2010 after its most recent expansion in 2008. Over the past twelve years, MHMRA’s psychiatric emergency services have nearly doubled, logging an 88% increase in the volume of service episodes from 12,899 in 2000 to 24,365 in 2011.

Target population: Individuals in need of mental health services. It is anticipated that the program will provide services for about 720 patients.

Category 1 or 2 expected patient benefits: MHMRA will:

- Provide 720 more initial interventions from baseline by DY5
- Increase percent of MCOT patients who follow up at MHMRA outpatient clinic within 30 days of discharge from MCOT by 10% from baseline by DY5.
- Reduce PES/HCPC admissions by 10% from baseline by DY5.

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction and functional status by 10% from baseline by DY5.
Project Option 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: Mobile crises unit (MCOT)

Unique RHP Project Identification Number: 113180703.2.5

Performing Provider Name/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Project Description:
*The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting by expansion of a mobile crises unit.*

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

MHMRA proposes to expand the current Mobile Crisis Outreach Team (MCOT), which provides mobile crisis outreach and follow-up to adults and children who are unable or unwilling to access traditional psychiatric services.

MCOT adopts a multidisciplinary approach to mental health treatment. When a consumer initiates an MCOT intervention, two trained MCOT staff respond to the consumers’ needs. Teams may meet with the patient in a variety of settings including in the consumer’s community, home, or school. MCOT provides assessment, intervention, education, and linkage to other services to address identified needs. For example, MCOT may facilitate a referral to a medical provider, nurse, outpatient psychiatric clinic, or inpatient psychiatric hospital. MCOT also provides nursing and medication management for consumers who are in need of this type of care. Additionally, the program may assist local medical emergency rooms that do not have a psychiatric presence by screening patients who may be in need of psychiatric emergency services.

MCOT provides case coordination services similar to MHMRA’s Chronic Consumer Stabilization Initiative (CCSI); however, MCOT provides short-term (4-6 weeks) stabilization interventions to consumers in need, whereas the CCSI is a long-term program. MHMRA’s Crisis Intervention Response Team (CIRT) is also a variation of mobile response, except that it provides only one initial crisis intervention by a team composed of a mental health professional and law enforcement officer and the CIRT team responds to police dispatch in an unmarked police car. CIRT interventions typically last several hours, compared to MCOT, which may last several weeks. It is also important to note that police officers are not part of the MCOT multidisciplinary team. There are times when a CIRT crisis response results in a referral to MCOT for follow-up and continued interventions.

Goals and Relationship to Regional Goals:
The primary goal of the program is to reduce preventable psychiatric hospital admissions among MCOT recipients. The second goal is to improve linkage to outpatient treatment. By accomplishing these goals, cost savings will be accrued. Finally, we seek to provide high quality services as reflected by patient satisfaction surveys and functional assessment of each patient. Process goals have been identified to ensure the program is well designed and reflects best practices.

**Challenges:**

The challenges include identifying appropriate ongoing service providers for linkage. This challenge will be addressed through expansion of outpatient behavioral health services for individuals with severe psychiatric conditions.

**Starting Point/Baseline:**

The existing MCOT program provides clinical intervention to approximately 1400 unduplicated individuals per year. The proposed program will expand the number of cases from 1,400 to about 2,100 per year. The baseline year will begin in year three with an additional 200 interventions. Year four would provide an additional 450 interventions from the baseline of 1400. Year five would provide 720 initial interventions from the baseline of 1400 for a total of 2120 interventions by end of year five.

**Rationale:**

Mobile crisis services offer several advantages, including decreased psychiatric emergency services, decreased service costs, increased community treatment, increased patient autonomy, and decreased burden on the community to expand emergency services. Mobile crisis services are well studied in the behavioral sciences literature. The most common outcome of mobile services is the reduction in preventable psychiatric hospitalizations. For example, Scott (2000) reported a 27% reduction in hospitalization rates, coupled with a 23% decrease in costs. Similarly, Hugo, Smout, and Bannister (2002) reported a 30% decrease in hospitalization rates when mobile crisis services were utilized. Our own program evaluation indicated MCOT interventions rarely result in inpatient admissions (e.g., less than 5% of service calls). The cost savings that result from preventable admissions is discussed below in the valuation section.

Mobile crisis services also seek to improve access to appropriate levels of treatment, such as linkage to community outpatient services. By engaging a consumer via mobile services, and successfully linking them to community treatment, our agency ensures the consumer is treated in the least restrictive environment possible. Again, MHMRA data indicates the longer a consumer is engaged in MCOT services (e.g., 3-4 weeks versus 1-2 weeks), the less likely the consumer is to return to the hospital immediately and the more likely the consumer is to access outpatient treatment.

Houston is a large city with a population of over 4.2 million. State and local data indicates an increased demand for mental health services. MHMRA data also supports this theory. For example, MCOT has grown by more than 52% since inception in 2004, from 1,224 episodes of care to 1,861 episodes in 2011. The program reached its current peak capacity in 2010 after its most recent expansion in 2008. Over the past twelve years, MHMRA’s psychiatric emergency services have nearly doubled, logging an 88% increase in the volume of service episodes from 12,899 in 2000 to 24,365 in 2011. Further expansion is likely limited primarily by capacity.
Project Components:

In order to enhance the transition from inpatient to develop such a program, the following option and core components were chosen: 2.13.1, Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. These components have also been imbedded in the program process and improvement milestones (See milestone and metric chart for further details). The status of each component is noted, if that activity is currently underway:

a) Assess size, characteristics and needs of target population(s)
   - In progress. MHMRA is in the process of completing a needs assessment to determine the number of consumers who may benefit from this expansion and the treatment needs of these consumers.

b) Review literature / experience with populations similar to target population.
   - To be completed. MHMRA will look to expert authorities and national resources, such as SAMHSA, prior to implementing specific treatment approaches or adopting specific manuals/materials.

c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.
   - To be completed. MHMRA will develop a program evaluation that includes qualitative and quantitative metrics (e.g., pre/post assessment of program participants, use of psychiatric emergency services, jail bookings, patient satisfaction surveys, etc.)

d) Design models which include an appropriate range of community-based services and residential supports.
   - In progress. MHMRA consumers often need assistance with transportation, housing, and medical needs. MHMRA clinicians currently address these needs using existing psychoeducational material. Additionally, MHMRA has a residential program that may be used by consumers if they need transitional housing.

e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.
   - To be completed. MHMRA will work with the outcomes department to identify pre/post measures and patient satisfaction surveys that are empirically validated for individuals who are diagnosed with co-morbid conditions. See Category 3 Outcome for more details.

f) Community-based interventions should be comprehensive and multispecialty.
   - As mentioned above, this program is inherently multidisciplinary.

Unique community need identification number the project addresses:

This project directly meets broad goals identified by the regional needs assessment. First, it improves on existing programs and infrastructure by filling a void that is unmet by existing psychiatric outpatient clinics and psychiatric emergency services. Second, it increases access to specialty care services by providing mobile treatment. The program also offers a preventative, patient-centered approach that provides short-term mental health treatment to those in urgent need. The proposed program will also complement the regional need to develop a culture of
“best practices” whereby the patient plays a more active role as a stakeholder by completing patient satisfaction surveys.

The MCOT Expansion will address the following community needs: CN2-Insufficient Access to Behavioral Health; CN5- Integrated Care for Behavioral Health; CN12- Improved Access to Patient Education; and CN14-Reduction of ER Services.

**Relationship to other Projects:** At this time there is not enough information available from the RHP to describe how this project may or may not be related to other RHP DSRIP proposals. However, the proposed project complements several MHMRA DSRIP proposals, including the expansion of the Crisis Residential Unit and expansion of the Chronic Consumer Stabilization Initiative. All three proposals seek to expand psychiatric stabilization while reducing inpatient admissions.

Numerous community needs assessments reflect an extreme need for behavioral health services to include outpatient treatment centers, crisis stabilization units, inpatient beds, and much more. The lack of funding as well as complexity of the regions patient base has limited the amount of behavioral health treatments available to our region and continues to drive cost in emergent and inpatient situations. The Crisis Stabilization Unit has a direct correlation to all behavioral health programs recommended in the RHP plan and will be a focus of two of the largest Local Mental Health Authorities of our region. Both CSU’s share the outcome measures of mental health admissions & readmissions, and improvement of patient satisfaction scores. The Region 3 Initiative Grid attached in the addendum reflects the direct relationships of this initiative.

The specific community needs that the proposed program addresses include:
- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

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

**Project Valuation:**
In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

The following valuation is aligned with the demonstration program goals to develop programs that enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. The primary valuation method
uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

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

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the intervention is cost effective. The number of life-years added is based on a review of the scientific literature.

**Cost-Utility Analysis:** After an exhaustive review of the literature, no studies were located that contained a QALY for mobile crisis services; therefore the valuation proposed is limited to cost savings studies.

**Cost-Effectiveness and Cost Savings:** Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. We did identify a benefit-cost study that is related.

As previously discussed, Scott (2000) showed that people with mental illness using mobile crisis services avoided hospitalizations in 55% of the cases in Alabama compared those who received police intervention (28%) resulting in a net reduction of 27% in hospitalization. Additionally, MCOT services were 23% less costly per person ($2,295, 2012 US Dollars) compared to those served by the police department ($2,964). These costs include both program costs and hospitalization costs. Similar results were found in a study that compared mobile crisis assessment to emergency room assessment (Hugo, Smout & Bannister 2002). Their study showed that the 298 individuals receiving MCOT were 30% less likely to be admitted to a psychiatric inpatient unit compared to individuals served within an emergency room, regardless of their clinical characteristics.

The average reduction in hospitalization rate between these two studies is 28.5% (27+30/2). It is important to note the average cost of inpatient hospitalization in the Harris County Hospital District is $700 per day, with an average length of stay of 10.25 days (SD=7.23, N=33,680).

\[
\begin{align*}
100 & \quad \text{(People served)} \\
.285 & \quad \text{(Reduction in inpatient admissions, or 28.5%)} \\
$700 & \quad \text{(Average cost per hospital day)} \\
\times 10.25 & \quad \text{(Average psychiatric hospital length of stay)} \\
\text{=} & \quad \text{Total Valuation} \\
$204,487.50 & \quad \text{(Total Valuation)}
\end{align*}
\]
Additional Costs: Hickey, Strang & Cantu (2012) reported that MHMRA of Harris County adult outpatient care reduced the annual percentage of individuals booked into the County Jail by 5% during an average 1.33 year treatment episode when compared to the rate in the year prior to admission to outpatient services. An average length of incarceration for mentally ill offenders in the County Jail is 40.73 days (Nguyen, Hickey & Farenthold, 2005). At a cost of $130/day for individuals receiving mental health care inside the jail, the cost savings can be estimated as (5% reduction x 40.73 days x $130/day x 100 served) $264,949 per 100 served.

Valuation: This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). All valuations used 100 individuals that would receive all components of the program. Assuming a reduction of 28.5% in hospitalization rates, an average length of stay of 10.25 days, and $700 per day, the total valuation is estimated at nearly $205,000 per 100 individuals served. With the addition of jail avoidance costs ($264,949) the total valuation would be $469,949 per 100 served. Since the project aims to serve 720 patients, the total valuation ($469,949 X 720/100) is $3,383,632.80.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1:</strong> P-2. Refine MCOT treatment program to provide empirically based services</td>
<td><strong>Milestone 2:</strong> P-3. Enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness who are unable or unwilling to access emergency and routine psychiatric care.)</td>
<td><strong>Milestone 6:</strong> P-3. Enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness who are unable or unwilling to access emergency and routine psychiatric care.)</td>
<td><strong>Milestone 9:</strong> P-3. Enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness who are unable or unwilling to access emergency and routine psychiatric care.)</td>
</tr>
<tr>
<td><strong>Metric 1:</strong> P-2.1. Project plans will be based on empirically supported treatment approaches such as those proffered by SAMHSA</td>
<td><strong>Metric 1:</strong> P-3.1. Number of intakes/initial services completed by MCOT</td>
<td><strong>Metric 1:</strong> P-3.1. Number of intakes/initial services completed by MCOT</td>
<td><strong>Metric 1:</strong> P-3.1. Number of intakes/initial services completed by MCOT</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Written plan</td>
<td><strong>Data Source:</strong> Project documentation</td>
<td><strong>Data Source:</strong> Project documentation</td>
<td><strong>Data Source:</strong> Project documentation</td>
</tr>
<tr>
<td><strong>Goal:</strong> Provide 200 more initial interventions from baseline</td>
<td><strong>Goal:</strong> Provide 450 more initial interventions from baseline (250 increase from YR3)</td>
<td><strong>Goal:</strong> Provide 720 more initial interventions from baseline (270 increase from YR 4)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incentive Payment: $</th>
<th>Incentive Payment: $</th>
<th>Incentive Payment: $</th>
<th>Incentive Payment: $</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,707,923.66</td>
<td>$744,216.04</td>
<td>$1,060,365.90</td>
<td>$1,024,508.11</td>
</tr>
<tr>
<td>113180703.2.5</td>
<td>2.13.1</td>
<td>2.13.1: .1a, .1b, .1c, .1d, 1e</td>
<td>Mobile crises outreach team expansion</td>
</tr>
<tr>
<td>-------------</td>
<td>--------</td>
<td>-----------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td>IT-6.1</td>
<td>10.1</td>
</tr>
</tbody>
</table>

**Related Category 3 Measure(s):**
- Patient satisfaction
- Functional status

<table>
<thead>
<tr>
<th>113180703.3.12</th>
<th>IT-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>113180703.3.34</td>
<td>IT</td>
<td>Percent improvement in functional status</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>


**Metric 1:** I-X.1 Establish a baseline of MCOT consumers’ inpatient admissions to HCPC.

**Data Source:** MHMRA and HCPC records


**Metric 1:** I-X.1 % decrease from baseline in HCPC admissions

- **Numerator:** Percent of patients receiving MCOT services admitted to HCPC during measurement period.
- **Denominator:** The number of patients receiving MCOT services

**Data Source:** MHMRA and HCPC records

**Goal:** 5% decrease in HCPC admissions from baseline


**Metric 1:** I-X.1. % decrease from baseline in HCPC admissions

- **Numerator:** Percent of patients receiving MCOT services admitted to HCPC during measurement period.
- **Denominator:** The number of patients receiving MCOT services

**Data Source:** MHMRA and HCPC records

**Goal:** 10% decrease in HCPC admissions from baseline

<table>
<thead>
<tr>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
</table>

**Incentive Payment:**
- N/A
- $744,216.04
- $1,060,365.90
- $1,024,508.11

Regional Healthcare Partnership Plan
Region 3
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Milestone 4: I-X. Follow Up with mental health treatment&lt;br&gt;&lt;br&gt;Metric 1: I-X.1. % increase in consumers' follow/up with outpatient mental health treatment within 30 days of discharge from MCOT&lt;br&gt;&lt;br&gt;Data Source: MHMRA electronic record and MCOT program data&lt;br&gt;&lt;br&gt;Goal: Establish a baseline of MCOT consumers' follow/up with outpatient, with the new patients served in DY 3</td>
<td>Milestone 8: I-X. Follow Up with mental health treatment&lt;br&gt;&lt;br&gt;Metric 1: I-X.1. % increase in consumers' follow/up with outpatient mental health treatment within 30 days of discharge from MCOT&lt;br&gt;&lt;br&gt;a. Numerator: Percent of MCOT patients who follow up at MHMRA outpatient clinic within 30 days of discharge from MCOT&lt;br&gt;&lt;br&gt;b. Denominator: The number of patients receiving MCOT services&lt;br&gt;&lt;br&gt;Data Source: MHMRA/MCOT data&lt;br&gt;&lt;br&gt;Goal: 5% increase from baseline</td>
<td>Milestone 11: I-X. Follow Up with mental health treatment&lt;br&gt;&lt;br&gt;Metric 1: I-X.1. % increase in consumers' follow/up with outpatient mental health treatment within 30 days of discharge from MCOT&lt;br&gt;&lt;br&gt;a. Numerator: Percent of MCOT patients who follow up at MHMRA outpatient clinic within 30 days of discharge from MCOT&lt;br&gt;&lt;br&gt;b. Denominator: The number of patients receiving MCOT services&lt;br&gt;&lt;br&gt;Data Source: MHMRA/MCOT data&lt;br&lt;br&gt;Goal: 10% increase from baseline</td>
</tr>
<tr>
<td>N/A</td>
<td>Incentive Payment $</td>
<td>Incentive Payment: $</td>
<td>Incentive Payment: $</td>
</tr>
<tr>
<td>N/A</td>
<td>$744,216.04</td>
<td>$1,060,365.90</td>
<td>$1,024,508.11</td>
</tr>
<tr>
<td>N/A</td>
<td>Milestone 5: P- 4. Hire and train staff to implement MCOT expansion.&lt;br&gt;&lt;br&gt;Metric 5: P- 4.1. 100% staff hired and trained by end of YR3&lt;br&gt;&lt;br&gt;Data Source: Human Resource records</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>113180703.2.5</td>
<td>2.13.1</td>
<td>2.13.1: .1a, .1b, .1c, .1d, 1e</td>
<td>Mobile crises outreach team expansion</td>
</tr>
<tr>
<td>---------------</td>
<td>--------</td>
<td>---------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
</tr>
</tbody>
</table>

**Related Category 3 Measure(s):**
- Patient satisfaction
- Functional status

<table>
<thead>
<tr>
<th>Measure Code</th>
<th>Measure Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>113180703.3.12</td>
<td>IT-6.1 IT 10.1 Percent improvement over baseline of patient satisfaction scores</td>
</tr>
<tr>
<td>113180703.34</td>
<td>Percent improvement in functional status</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Incentive Payment $744,216.04</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount: $</th>
<th>Year 3 Estimated Milestone Bundle Amount: $</th>
<th>Year 4 Estimated Milestone Bundle Amount: $</th>
<th>Year 5 Estimated Milestone Bundle Amount: $</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,707,923.66</td>
<td>$2,976,864.16</td>
<td>$3,181,097.69</td>
<td>$3,073,524.33</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $11,939,409.84
REFERENCES


2.13 PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING: Transitional Residential Treatment Post-Incarceration

RHP Project Number: 113180703.2.6  
TPI: 113180703

Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid.

Intervention(s): MHMRA proposes a 25-bed residential facility to provide supportive housing to individuals who are at risk for mental health crisis due to recent release from Harris County Jail. This program would provide transitional services for up to 60 days with the goal of linking clients with outpatient psychiatric treatment, medical services, and social security benefits or employment through the Department of Assistive and Rehabilitative Services (DARS). Peer supporters will offer counseling, peer led groups, assistance in resource identification, coping skills enhancement, substance abuse and mental health treatment and models of behavioral change.

Need for the project: Currently there are no programs that provide temporary housing for recent inmates while they are attempting to re-enter society. Such a program is needed due to the significant overlap between crime and mental health issues. Even individuals without a history of mental health issues may enter a crisis upon their release when there are no supports.

Target population: Individuals who are at risk for mental health crisis due to recent release from Harris County Jail. It is anticipated the program will provide service for about 200 patients.

Category 1 or 2 expected patient benefits: MHMRA will

- Enroll and serve 200 patients by DY5
- Reduce readmission rate to criminal justice system by 10% by DY 5 and
- Reduce readmission rate to psychiatric emergency services by 10% by DY 5

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction and functional status by 10% from baseline by DY5.
2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Transitional Residential treatment post-Incarceration

Unique RHP Project Identification Number: 113180703.2.6
Performing Provider Name/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: transitional residential treatment post-Incarceration.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

MHMRA proposes a 25-bed residential facility to provide transitional housing and treatment to individuals who are at risk for mental health crisis due to recent release from Harris County Jail. These individuals are at heightened risk for destabilization subsequent to the mental health stressors of incarceration and poor supports in the community. They often have difficulty accessing mental health treatment, medical interventions, secure housing and other beneficial supports. This program would provide transitional services for up to 60 days with the goal of linking clients with outpatient psychiatric treatment, medical services, and social security benefits or employment through the Department of Assistive and Rehabilitative Services (DARS). Peer support is an essential element of the program; peers will co-lead 2 – 3 groups per day to enhance coping skills, identify resources and model behavioral changes that will improve efficacy in community interactions. Integrated interventions aimed at reducing substance abuse and symptoms of mental disorder will be offered for residents with these co-morbid conditions (estimated at 30-50% of the population).

Goals and Relationship to Regional Goals:
The five year goal is to establish a transitional housing program tailored to meet the needs of formerly incarcerated individuals. The program seeks to serve 100 clients per year, beginning in DY4, by providing cognitive behavioral therapy and psycho-education (e.g., symptom management, problem solving and coping skills, strengths and recovery-building training, self-advocacy and after-care). The milestones we selected are to reduce unnecessary inpatient hospitalizations, reduce criminal recidivism, and provide transitional housing and community mental health treatment.

Challenges:
One of the biggest challenges for ex-offenders is overcoming the dual stigmas associated with incarceration and mental illness. These stigmas often constitute barriers to obtaining high-quality mental health and social support services. Although offenders have technically paid their debt to society (e.g., via incarceration), there are many potential stumbling blocks in the path toward obtaining adequate employment, support services and education in order to regain a viable status within society. Because of frequent recidivism and public safety concerns, this population is an unpopular one for which to provide advocacy. We plan to address this challenge by meeting regularly with stakeholders and other performing partners and by providing education about the needs of this population and their families and the societal benefits of addressing these needs.

Starting Point/Baseline:
Currently there are no supportive psychiatric housing programs for post-incarceration in the Houston area.

Rationale: Research indicates half of all prison and jail inmates have a mental health problem (James & Glaze, 2006). The percent of mental illness varies depending on the setting. For example, 56% of state prisoners, 45% of federal prisoners, and 64% of jail inmates are reported to have a diagnosed mental illness. The findings in this report were based on data from personal interviews with state and federal prisoners in 2004 and jail inmates in 2002. Whether an individual has a pre-existing mental illness or not, the psychosocial stress related to incarceration and re-entry without support are sufficient to lead to mental health crises.

In addition to mental health issues, this population commonly experiences other barriers to re-entry such as substance abuse, physical health problems, homelessness and employability issues. Between 20% and 38% of those with infectious diseases, such as HIV and tuberculosis, have been in the prison system and will need ongoing medical treatment upon release (Travis, Solomon & Waul, 2001).

According to Travis et al., (2001) prison health systems are significant providers of health and behavioral health services to a largely indigent population. Travis and colleagues also noted that individuals who are gainfully employed, and are paid adequately are less likely to commit future crimes and be incarcerated than those who are not employed. By providing supportive housing, mental health and substance abuse treatment, employment training and linkage to other needed services, those being released from jails and prisons may be able to reduce their recidivism and become more stable, productive members of society. A further consideration is that most re-arrests and re-incarceration among the population of individuals released from jails and prisons occurs within 6 months of discharge (Dunn & Coughlin, 2008). Being able to address mental health, housing, medical and social supports at release is expected to reduce the number of re-arrests and re-incarcerations that occur in the few months after initial release.

Summary: The post-incarceration transitional housing treatment program will address mental health concerns involving individuals who might otherwise re-offend or over-use more expensive and less-efficient emergency and inpatient services. This program is proposed due to the clear understanding that incarceration imposes psychological stressors on most inmates and the burdens are more heavily borne by individuals with pre-existing psychiatric diagnoses.
Outcomes will be measured using the ANSA to identify improvements in functioning and by evaluating the arrest/incarceration histories of residents receiving treatment both before treatment and after treatment. In addition, the histories of residents in the post-incarceration transitional housing treatment program will be reviewed to determine frequency of use of emergency psychiatric services both before incarceration and after treatment. Finally, linkages to medical and social support services will be demonstrated by the fact of the linkages, as well as by a reduction in recidivism and use of expensive emergency services.

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

IT 6.1 Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction.

**IT- 9.4 Other Outcome Improvement Target:** Percent decrease in psychiatric symptoms that provoke behavioral crises

**Project Components:**

In order to develop the program described above, the following option and core components were chosen: 2.13.1, Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. These components have also been imbedded in the program process and improvement milestones (See milestone and metric chart for further details).

A. MHMRA will assess size, characteristics and needs of the post-incarcerated population through collaborations with local agencies.

B. MHMRA will review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, forensic encounters, or incarceration, while improving quality of life.

C. Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.

D. Design models which include an appropriate range of community-based services and residential supports.

E. Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.

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

This project directly meets broad goals identified by the regional needs assessment. First, it improves on existing programs and infrastructure by filling a void that is unmet by existing psychiatric outpatient clinics and psychiatric emergency services. Second, it increases access to specialty care services by providing these services to a disenfranchised population. The program also offers a preventative, patient-centered approach that provides short-term mental health treatment to those without other resources. By providing such services the community problem of increased demand on criminal justice system will be addressed. The proposed program will also complement the regional need to develop a culture of “best practices” whereby the patient plays a more active role as a stakeholder by completing patient satisfaction surveys. The program is expected to reduce the re-incarceration rates of individuals who complete it and is
also expected to improve the general functional well-being of its residents (ANSA scores) so that they are better able to cope with the stressors of life in the free world.

The proposed program will address the following community needs:

- CN2-Insufficient Access to Behavioral Health
- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions
- CN18- Insufficient access to integrated care programs for behavioral health and physical health conditions

**Relationship to other Projects:** The proposed project complements several MHMRA DSRIP proposals, including the expansion of the Crisis Residential Unit and expansion of the Chronic Consumer Stabilization Initiative. All three proposals seek to expand psychiatric stabilization while reducing inpatient admissions.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

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

**Project Valuation:** In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

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

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature.

Cost-Utility Analysis: Although no direct studies of this type were found, a study related to housing for persons living with HIV seemed relevant. A cost-utility analysis by Holtgrave and colleagues (2012) was based on data from the Housing and Health (H&H) study of rental assistance for homeless and unstably housed persons living with HIV in Baltimore, Chicago, and Los Angeles. They combined these outcome data with information on intervention costs to estimate the cost-per-QALY gained. They estimated that the cost-per-QALY-saved by the HIV-related housing services is $62,493. They also found that 0.0324 QALYs were gained due to improvements in perceived stress and thereby, quality of life.

For this valuation we focus on housing assistance. Assuming our 100 participants who each participate in crisis residential program, the total value gained from this component would be:

\[
100 \times 0.0324 \times \$50,000 = \$162,000
\]

Cost-effectiveness and Cost Savings: Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. We identified several related cost-benefit studies.

Crisis Residential Treatment: Research indicates crisis residential units are more cost effective than inpatient hospitals; in 2002, Fenton and team found the mean cost of an acute treatment episode was 44% lower per treatment in a residential crisis program as compared to treatment at a general hospital. They found an average savings of $17,504 (2012 US dollars) per acute care episode per year (treated in residential crisis program rather than a general hospital). Sledge and colleagues (1996) found similar results; they reported that when patients were randomly assigned to crisis respite care rather than hospitalization, respite care costs were $13,585 (2012 US dollars) lower per year. The average cost savings between these two studies was $15,544.

A study conducted by Adams and El-Mallakh (2009) investigated crisis stabilization services in Kentucky. The authors determined the cost for one day of care of crisis stabilization was $195 (in 2012 US dollars), while the cost for a day at the state hospital was $488 (in 2012 US dollars) – a savings of $293 per day. Although the Adams and El-Mallakh (2009) study is relevant, the study design did not randomize the patients; therefore it was not used to value this project.
Based on average savings of $15,544 per acute care episode per year (treated in residential crisis program rather than a general hospital):

\[
100 \text{ (persons served)} \\
\times \$15,544 \text{ (savings per acute care episode)} \\
= \$1,554,400 \text{ Cost Savings}
\]

**Dual Disorder (Substance Abuse and Residential) Treatment:** French, Salomé & Carney, et al. (2002b) estimated the costs and benefits of residential addiction treatment at five programs in the State of Washington that serve publicly funded clients. They reported an average (per client) total economic benefit was $58,868 (2012 US Dollars) over one year, leading to estimates of $45,314 for average net benefit and 4.34 for the benefit–cost ratio.

The benefits and costs associated with mutual-help community-based recovery homes were reported by Lo Sasso, Byro, Jason, Ferrari and Olson (2012). They noted that the intervention compared quite favorably to usual care: the net benefit was estimated to be between $9,450 and $15,370 (2012 US Dollars) per person per year on average, depending on the method employed.

In a study with a more comparable target sample, French and colleagues examined the effectiveness of a therapeutic community for homeless mentally ill chemically dependent consumers (French, McCollister, Sacks, McKendrick & De Leon, 2002a). Among this homeless, mentally ill sample the incremental economic benefit estimate was $163,708 (2012 US Dollars), net benefit was $132,148, and the benefit–cost ratio was 5.2.

Community residential treatment for those with dual (mental health and substance abuse) disorders has been observed to reduce subsequent health care costs by half, a value of $13,288 per treated individual when compared to hospital care (Timko, Shuo, Sempel & Barnett, 2006).

An average across the four relevant studies yields an estimated annual savings per treated person of $33,341. Since the residential substance abuse treatment cannot clearly be identified as a unique contributor to positive outcome above and beyond the crisis residential treatment component, its value is offered as indication of probable additional benefit but this value will not be added to the overall valuation.

**Additional Cost Savings:** Buck, Brown & Hickey (2011) reported on a less intensive intervention with just-released mentally ill jail offenders in Harris County. Results indicate that those who were linked to services after their release had arrest rates that were 36% lower one year after contact with the program compared with the number of arrests one year before contact with the program. Also, the average number of days spent in jail decreased by 23, from 65 to 42 days during the year after contact with the program. Total annual criminal charges (misdemeanors and felonies) for each participant had also been reduced by 56% during the year after contact with the program.

Using the Buck et al., (2011) data and an estimated 23 day reduction in incarceration, we can calculate an estimated savings of $2,990 per treated individual, since the cost of a jail day for an individual with mental disorders is locally estimated at $130 (Harris County Office of Budget Management, personal communication). Summed across 100 patients the savings is $299,000.

**Summary and Total Valuation:** This valuation analysis shows that the intervention will
have a positive value for participants who receive the intervention(s). The total expected value of benefits, based on the average of the Fenton article and the Sledge et al. article, is $1,554,400. The Fenton et al., (2002) study’s QALY-based estimate was $162,000. Jail avoidance would contribute an additional $299,000. The total valuation is $2,015,400. In addition, other studies have shown this program will likely result in additional cost-savings. Since the program is projected to serve 200 patients, the total value will be ($2,015,400 x 2 x 100) $4,030,800 per year.
### Related Category 3 Measure(s):

<table>
<thead>
<tr>
<th>Unique Category 3 Project IDs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>113180703.3.13</td>
</tr>
<tr>
<td>113180703.3.35</td>
</tr>
</tbody>
</table>

### Year 2 (10/1/2012 – 9/30/2013)

<table>
<thead>
<tr>
<th>Milestone 1: P-1. Conduct needs assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1:</strong> P-1.1. Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional issues, criminal justice and psychiatric needs</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project documentation; criminal justice records; public psychiatric facility records; survey of stakeholders</td>
</tr>
</tbody>
</table>

### Year 3 (10/1/2013 – 9/30/2014)

<table>
<thead>
<tr>
<th>Milestone 2: P-2. Design community-based specialized interventions for post-incarceration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 2:</strong> P-2.1. Project plans will be based on empirically based treatment approaches such as those proffered by SAMHSA</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Written plan</td>
</tr>
<tr>
<td><strong>Goal:</strong> complete project plan</td>
</tr>
</tbody>
</table>

### Estimated Incentive Payment

- **$3,225,852.01**

### Year 4 (10/1/2014 – 9/30/2015)

<table>
<thead>
<tr>
<th>Milestone 5: P-3. Enroll and Serve individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 2:</strong> P-3.1. Number of targeted individuals enrolled</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project reports</td>
</tr>
<tr>
<td><strong>Goal:</strong> Enroll and serve 100 patients</td>
</tr>
</tbody>
</table>

### Estimated Incentive Payment

- **$1,263,175.73**

### Year 5 (10/1/2015 – 9/30/2016)

<table>
<thead>
<tr>
<th>Milestone 8: P-3. Enroll and Serve individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 8:</strong> P-3.1. Number of targeted individuals enrolled</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project reports</td>
</tr>
<tr>
<td><strong>Goal:</strong> Enroll and serve 100 patients (100 new patients from YR4)</td>
</tr>
</tbody>
</table>

### Estimated Incentive Payment

- **$1,220,459.64**
<table>
<thead>
<tr>
<th>113180703.2.6</th>
<th>2.13.1</th>
<th>2.13.1: .1a, .1b, .1c, .1d, .1e</th>
<th>Transitional residential treatment post-incarceration</th>
</tr>
</thead>
</table>

Mental Health and Mental Retardation Authority of Harris County 113180703

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

**Unique Category 3 Project IDs:**
- 113180703.3.13
- 113180703.3.35

**IT-6.1**

**IT-10.1**

**Improvement of patient satisfaction scores**

**Improvement in functional status**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

| N/A | Milestone 3: I-1. Criminal Justice Admissions/Readmissions Metric 3: I- 1.1. X% decrease in preventable admissions and readmissions into CriminalJustice System a. Numerator: The percentage of individuals receiving specialized interventions that had a potentially preventable admission/readmission into a criminal justice setting b. Denominator: The number of individuals receiving specialized interventions. **Data Source:** County jail records **Goal:** Establish baseline | Milestone 6: I-1: Criminal Justice Admissions/Readmissions Metric 6: I- 1.1. : X% decrease in preventable admissions and readmissions into CriminalJustice System; **Data Source:** County jail records **Goal:** Reduce readmission rate by 5% | Milestone 9: I-1: Criminal Justice Admissions/Readmissions Metric 9: I- 1.1. : X% decrease in preventable admissions and readmissions into CriminalJustice System; **Data Source:** County jail records **Goal:** Reduce readmission rate by 10% |

| N/A | Estimated Incentive Payment: $1,182,077.05 | Estimated Incentive Payment: $1,263,175.74 | Estimated Incentive Payment: $1,220,459.65 |

---

**Regional Healthcare Partnership Plan**

**Region 3**
<table>
<thead>
<tr>
<th><strong>113180703.2.6</strong></th>
<th><strong>2.13.1</strong></th>
<th><strong>2.13.1: .1a, .1b, .1c, .1d, .1e</strong></th>
<th><strong>Transitional residential treatment post-incarceration</strong></th>
</tr>
</thead>
</table>

**Mental Health and Mental Retardation Authority of Harris County**

**113180703**

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

**Unique Category 3 Project IDs:**
- 113180703.3.13
- 113180703.3.35

**IT-6.1**

**IT-10.1**

** Improvement of patient satisfaction scores**

**Improvement in functional status**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| N/A                           | Milestone 4: I- X. Psychiatric Emergency Service (PES) Readmissions and Inpatient Public Hospital Admissions **Metric 4: I- X.1. % decrease from baseline in HCPC**
  a. Numerator: Percent of patients receiving services admitted to HCPC during measurement period.
  b. Denominator: The number of patients receiving services
  **Data Source:** MHMRA and HCPC records
  **Goal:** Establish baseline | Milestone 7: I- X. Psychiatric Emergency Service (PES) Readmissions and Inpatient Public Hospital Admissions **Metric 7: I- X.1. % decrease from baseline in HCPC**
  **Data Source:** MHMRA and HCPC records
  **Goal:** Reduce readmission rate by 5% from baseline | Milestone 10: I- X. Psychiatric Emergency Service (PES) Readmissions and Inpatient Public Hospital Admissions **Metric 10: I- X.1. % decrease from baseline in HCPC**
  **Data Source:** MHMRA and HCPC records
  **Goal:** Reduce readmission by 10% from baseline |
| N/A                           | Estimated Incentive Payment: $1,182,077.05 | Estimated Incentive Payment: $1,263,175.74 | Estimated Incentive Payment: $1,220,459.65 |
| Year 2 Estimated Milestone Bundle Amount: $3,225,852.01 | Year 3 Estimated Milestone Bundle Amount: $3,546,231.15 | Year 4 Estimated Milestone Bundle Amount: $3,789,527.21 | Year 5 Estimated Milestone Bundle Amount: $3,661,378.94 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $14,222,989.31
REFERENCES


2.13 PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING: CRISIS INTERVENTION RESPONSE TEAM (CIRT)

RHP Project Number: 113180703.2.7

Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid.

Intervention(s): We propose an expansion of three additional teams of the Crisis Intervention Response Team (CIRT), which is a program that partners law enforcement officers who are certified in crisis intervention training with licensed master-level clinicians to respond to law enforcement calls. Together, these teams respond to calls involving individuals in serious mental health crises. Additionally, the team responds to SWAT team calls and conducts follow-up investigations on individuals when indicated.

Need for the project: it is the only program that partners directly with law enforcement agencies. CIRT also plays a critical role in addressing unmet needs in a population with a high base rate of mental illness—those who interface with criminal justice agencies. It is also important to note that many of these individuals do not require detention and may be treated effectively in the community. Furthermore, detention may be traumatizing for the patient, making him/her less likely to interface with treatment professionals in the future. Thus, CIRT plays a vital role in de-escalating conflict, providing mental health assessment, and decreasing unnecessary arrests.

Target population: Individuals in crisis and require law enforcement intervention. It is anticipated the program will provide service for about 1005 patients.

Category 1 or 2 expected patient benefits: MHMRA will:

- Respond to 15% more CIRT calls than baseline by DY5.
- Increase the percent of CIRT cases that result in resolution on-site by % to be determined.

Category 3 outcomes: MHMRA expects to decrease mental health admissions and readmissions to criminal justice settings by 10% from baseline by DY5. Also, MHMRA expects to increase patient satisfaction with provider communication by 10% from baseline by DY5.
2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: Crises Intervention Response Team (CIRT)

Unique RHP Project Identification Number: 113180703.2.7
Performing Provider name/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting by expansion of a crises intervention response team.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. In an effort to provide needed services to the most critically ill population, MHMRA proposes to increase outpatient capacity by approximately 500 individuals potentially eliminating the current wait list for services in this geographic area. In order to address this issue we will choose to focus on project option 1.12.2: Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

We propose an expansion of the Crisis Intervention Response Team (CIRT), which is a program that partners law enforcement officers who are certified in crisis intervention training with licensed master-level clinicians to respond to law enforcement calls. Together, these teams respond to calls involving with individuals in serious mental health crises. Additionally, the team responds to SWAT team calls and conducts follow-up investigations on individuals when indicated. While the team works collaboratively, the officer’s role includes transportation and security, whereas the clinician’s role is de-escalation, assessment, and resolution of the problem. The program operates in partnership with Houston Police Department and the Harris County Sheriff’s Office. The proposed project seeks to expand this program by adding more CIRT teams to respond to crises.

Goals and Relationship to Regional Goals:
The goal of the program is to assist law enforcement officers in the de-escalation of crises and provide appropriate mental health treatment during a crisis. First, we expect an increase in the number of law enforcement calls that have a CIRT team response. Second, we plan to see a decrease in the number of hospital admissions for recipients of the CIRT intervention. Additionally, we hope the percent of CIRT calls that end with a peaceful resolution increase. Finally, in Category 3, we plan to see a decrease in arrests. It is also important to note process milestones have been selected which pertain to the development of this program, such as adding new CIRT teams and engaging in continuous quality improvement. The overall five-year
outcome is to create a total of 3 new CIRT teams to accomplish these goals. Specific milestones and metrics are outlined in the Category 2 and 3 charts, which follow this narrative.

The estimated patient impact of adding additional CIRT clinicians will be immediate access to appropriate Mental Health services as well as a decrease in incarcerations. These will be measured by admissions to public psychiatric ER visits and the number of people diverted from jail to mental health services. This can be measured by the number of people CIRT serves and sends to Mental Health care versus the number of people CIRT serves that are taken to jail. This number is a variant number that will change depending on the population that is served in any given year.

**Challenges:**

The challenges include identifying appropriate ongoing service providers for linkage. This challenge will be addressed through expansion of outpatient behavioral health services for individuals with severe psychiatric conditions.

**Starting Point/Baseline:**

MHMRA currently has a small CIRT unit which consists of thirteen teams. Specifically, this proposal seeks to add three more teams. The baseline year will begin in year three with the three new CIRT teams responding to calls and a baseline being established for number of calls. In DY 4 we anticipate a 20% increase in the number of calls for the new teams and in DY5 a 40% increase over baseline of new teams.

**Rationale:**

Law enforcement is often the front-line response to people experiencing mental health crises; however, until recently, law enforcement officers have had little to no mental health training (Hails & Borum, 2003). Recent studies that examined the impact of CIRT teams have found that partnerships between law enforcement and mental health system improve collaboration, efficiency, and the treatment of people with mental illness. Additionally, mobile services have been found to decrease inpatient hospital admissions. For example, Scott (2000) reported a 27% reduction in hospitalization rates, coupled with a 23% decrease in costs. Similarly, Hugo, Smout, and Bannister (2002) reported a 30% decrease in hospitalization rates when mobile crisis services were utilized.

While MHMRA has several crisis intervention programs, CIRT is unique. Specifically, it is the only program that partners directly with law enforcement agencies. CIRT also plays a critical role in addressing unmet needs in a population with a high base rate of mental illness—those who interface with criminal justice agencies. It is also important to note that many of these individuals do not require detention and may be treated effectively in the community. Furthermore, detention may be traumatizing for the patient, making him/her less likely to interface with treatment professionals in the future. Thus, CIRT plays a vital role in de-escalating conflict, providing mental health assessment, and decreasing unnecessary arrests. Finally, CIRT provides an educative role in policing and may improve the competency of law enforcement officers who respond to psychiatric emergencies.

**Project Components:**

In order to enhance the transition from inpatient to develop such a program, the following option and core components were chosen: 2.13.1, Design, implement, and evaluate
research-supported and evidence-based interventions tailored towards individuals in the target population. These components have also been imbedded in the program process and improvement milestones (See milestone and metric chart for further details). The status of each component is noted, if that activity is currently underway:

a) Assess size, characteristics and needs of target population(s)
   - MHMRA will continue to assess characteristics and needs of individuals involved in crisis calls involving law enforcement agents.

b) Review literature / experience with populations similar to target population.
   - MHMRA will continue to review literature and evaluate ongoing experiences with individuals in crisis to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, forensic encounters, death and in promoting correspondingly positive health and social outcomes / quality of life.

c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.
   - MHMRA’s Outcome Management department will develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.

d) Design models which include an appropriate range of community-based services and residential supports.
   - MHMRA will continue to evaluate improvements on design models which include an appropriate range of community-based services and residential supports.

e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.
   - MHMRA will continue to assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.

f) Community-based interventions should be comprehensive and multispecialty.
   - As mentioned above, this program is inherently multidisciplinary.

Unique community needs identification number project addresses:

This project directly meets broad goals identified by the regional needs assessment. First, it improves on existing programs and infrastructure by filling a void that is unmet by existing psychiatric outpatient clinics and psychiatric emergency services. Second, it increases access to specialty care services by providing mobile treatment. The program also offers a patient-centered approach that provides short-term mental health treatment to those in urgent need. The proposed program will also complement the regional need to develop a culture of “best practices” whereby the patient receives collaborative treatment that is empirically supported by research.

The CIRT expansion will address the following community needs:
- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions
- CN10 High rates of preventable hospital admissions
**Relationship to other Projects:**

At this time there is not enough information available from the RHP to describe how this project may or may not be related to other RHP DSRIP proposals. However, the proposed project complements several MHMRA DSRIP proposals, including the expansion of the Crisis Residential Unit, Mobile Crisis Outreach Team, and Chronic Consumer Stabilization Initiative. All four proposals seek to expand psychiatric stabilization in the community while reducing inpatient admissions.

Numerous community needs assessments reflect an extreme need for behavioral health services to include outpatient treatment centers, crisis stabilization units, inpatient beds, and much more. The lack of funding as well as complexity of the regions patient base has limited the amount of behavioral health treatments available to our region and continues to drive cost in emergent and inpatient situations. The Crisis Stabilization Unit has a direct correlation to all behavioral health programs recommended in the RHP plan and will be a focus of two of the largest Local Mental Health Authorities of our region. Both CSU's share the outcome measures of mental health admissions & readmissions, and improvement of patient satisfaction scores. The Region 3 Initiative Grid attached in the addendum reflects the direct relationships of this initiative.

**Plan for Learning Collaborative:**

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

**Project Valuation:**

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency room visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added.
The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature.

**Cost-Utility Analysis:** After an exhaustive review of the literature, no studies were located that contained a QALY.

**Cost-Effectiveness and Cost Savings:** Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. We did identify a benefit-cost study that is related.

Outcomes studies have documented the benefits of mobile crisis teams, both with law enforcement involvement, and absent police presence. Scott (2000) assessed a psychiatric mobile outreach service in Alabama and compared the intervention to police intervention without the presence of a mental health professional. In this study, the mobile outreach service successfully avoided hospitalization among 55% of patients, compared to routine law enforcement interventions (28%, p<.01), for an overall reduction of 27%. Additionally, the average cost of mobile services with a police officer were 23% less per person ($1,520, a value equivalent to $2,034 in 2012 (U.S. Department of Labor, 2012)) compared to those served by the police department ($1,963); these costs include both program costs and hospitalization costs.

In 2010, Kisely and colleagues sought to evaluate the impact of an integrated mobile team that paired a plain-clothed police officer with a mental health professional (Kisely, Campbell, Peddle, Hare, Pyche, Spicer & Moore, 2010). The researchers used a mixed-method which provided a controlled before-and-after comparison of the intervention area with a control area without access to such a service. Services were assessed for one year before and two years after program implementation. The intervention (CIRT) was highly utilized within the community, evidenced by an increase in recipients from 464 to 1666 per year. Although the number of participants increased, the time spent per service was less in the experimental condition, 136 minutes than in the control group (165 minutes; Student t test = 3.4, df = 1649, P < 0.001). This reduction in intervention time may translate into cost savings in the future as consumers were diverted into outpatient and preventative services rather than expensive psychiatric emergency services.

Using the combined estimate of cost savings from Scott (2000), one can estimate the value of mobile crisis services as follows:

\[
\text{100 patients served} \\
\times \text{ $2,034 per person inflation adjusted savings} \\
= \text{ $203,400 Savings per 100 served}
\]

**Summary and Total Valuation:** This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention. All valuations used 100 individuals that would receive all components of the program. The total valuation is estimated at $203,400 per 100 individuals served per year.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1:</strong> P- X. Hire and train staff to implement CIRT expansion.</td>
<td><strong>Milestone 3:</strong> P- X. Hire and train staff to implement CIRT expansion.</td>
<td><strong>Milestone 6:</strong> P- X. Enroll and serve individuals with targeted complex needs.</td>
<td><strong>Milestone 8:</strong> P- X. Enroll and serve individuals with targeted complex needs.</td>
</tr>
<tr>
<td><strong>Metric 1:</strong> P- X.1. 33% staff hired and trained by end of YR 2</td>
<td><strong>Metric 1:</strong> P- X.1. 100% staff hired and trained by end of YR 3</td>
<td><strong>Metric 1:</strong> P- X.1. Number of calls in which CIRT responds</td>
<td><strong>Metric 1:</strong> P- X.1. Number of calls in which CIRT responds</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Human Resource records</td>
<td><strong>Data Source:</strong> Human Resource records</td>
<td><strong>Data Source:</strong> Project documentation</td>
<td><strong>Data Source:</strong> Project documentation</td>
</tr>
<tr>
<td><strong>Goal:</strong> Establish baseline</td>
<td><strong>Goal:</strong> estimated baseline will be determined (based on existing CIRT teams and call patterns)</td>
<td><strong>Goal:</strong> CIRT will respond to 20% more calls than baseline</td>
<td><strong>Goal:</strong> CIRT will respond to 40% more calls than baseline</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $818,255.43</td>
<td><strong>Estimated Incentive Payment:</strong> $599,680.93</td>
<td><strong>Estimated Incentive Payment:</strong> $961,234.81</td>
<td><strong>Estimated Incentive Payment:</strong> $928,729.28</td>
</tr>
<tr>
<td>Related Category 3 Measure(s): 113180703.3.14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>113180703.3.36</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health and Mental Retardation Authority of Harris County</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>113180703</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Crisis Intervention Response Team Expansion**

<table>
<thead>
<tr>
<th>IT- 9.1</th>
<th>IT- 6.1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decrease in mental health admissions and readmissions to criminal justice settings</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Patient Satisfaction</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2** (10/1/2012 – 9/30/2013)

**Year 3** (10/1/2013 – 9/30/2014)

**Year 4** (10/1/2014 – 9/30/2015)

**Year 5** (10/1/2015 – 9/30/2016)

**Milestone 5**: I- X. On-Site Crisis Resolution

**Metric 1**: I- X.1 Percent of CIRT cases that result in crisis resolution on-site

**Data Source**: MHMRA and law enforcement records

**Goal**: Establish estimated baseline (based on existing CIRT teams and call patterns)

**Estimated Incentive Payment**: $

### Year 2 Estimated Milestone Bundle:

$1,636,510.87

### Year 3 Estimated Milestone Bundle:

$1,799,042.80

### Year 4 Estimated Milestone Bundle:

$1,922,469.61

### Year 5 Estimated Milestone Bundle:

$1,857,458.56

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**: $

$7,215,481.83
REFERENCES


Mental Health and Mental Retardation Authority of Harris County
Pass 2
2.13 PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING: IDD/ASD WRAP-AROUND AND IN-HOME SERVICES

RHP Project Number: 113180703.2.8    TPI: 113180703

Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received IDD services in FY12, such as those being proposed in this project, 34.1% were medically indigent and 57.1% had Medicaid.

Intervention(s): The proposed program seeks to develop wrap-around and in-home services for high risk consumers with Intellectual and Developmental Disabilities and Autism Spectrum Disorders (IDD and ASD) and their families to avoid utilization of intensive, costlier services. More specifically, program staff will provide community based interventions for individuals to prevent them from cycling through multiple systems, by providing community-based, wrap-around services that help stabilize behavioral problems in the natural home, while linking the patient and family to other supports, such as a medical home, transition services to help individuals establish a stable living environment, peer support, employment, specialized therapies, respite, personal assistance, and linkage to short or long term residential options.

Need for the project: Harris County also has approximately 106,494 residents are with an intellectual and developmental disability; 24,000 with autism spectrum disorder; and of people in these groups, 38,700 are dually diagnosed with co-occurring mental illness. By providing timely intervention and linkage to community resources, individuals can be empowered to live independently or with their families, with minimal intrusion and maximum clinical benefit.

Target population: Harris County High risk consumers with Intellectual and Developmental Disabilities and Autism Spectrum Disorders (IDD and ASD) and their families. It is anticipated the program will provide service for about 100 patients.

Category 1 or 2 expected patient benefits:

- improvement in functional assessment (TBD) by 10% over baseline
- 10% decrease in admissions to State Supported Living Centers by DY 5

Category 3 outcomes: MHMRA expects to increase activities of daily living and patient satisfaction with communication with providers by 10% from baseline by DY5.
2.13: Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population- IDD/ASD Wrap-Around and In-Home Services

RHP Project ID: 113180703.2.8 / Pass 2

Performing Provider / TPI: Mental Health and Mental Retardation Authority of Harris County / 113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to design and implement a wrap-around in home service for IDD/ASD patients.

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves about 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received agency services in FY12, 60.0% were medically indigent and 32% had Medicaid. Of those who received IDD services, such as those being proposed in this project, 34.1% were medically indigent and 57.1% had Medicaid. With regard to incomes, 88% report family size and annual income placing them at or below 133% of 2012 Federal Poverty Level Guidelines. Only 5.2% of the agency’s clientele report incomes above 100% of FPL. Harris County’s ethnic diversity is reflected in the population served. Agency consumers self-describe the following ethnic backgrounds: African-Americans (34.5%), Anglos (27.1%), persons of Hispanic heritage (26.6%), Asian-Americans (2.8%) and those reporting other ethnicities (0.4%).

The proposed program seeks to develop wrap-around and in-home services for high-risk consumers with Intellectual and Developmental Disabilities (IDD) and/or Autism Spectrum Disorders (ASD) and their families to avoid utilization of intensive, costlier services. More specifically, program staff will provide community-based interventions for individuals to prevent them from cycling through multiple systems, by providing community-based, wrap-around services that help stabilize behavioral problems in the natural home, while linking the patient and family to other supports, such as a medical home, transition services to help individuals establish a stable living environment, peer support, employment, specialized therapies, respite, personal assistance, and linkage to short or long term residential options.

Goals:
MHMRA will provide specialized services to children and adults with IDD and/or ASD and behavioral problems. These individuals often have multiple concomitant issues such as physical health conditions, family stressors resulting from the person's disability, homelessness, cognitive challenges, lack of daily living skills, and lack of natural supports. Texas’s mental health system provides rehabilitative services and pharmacotherapy to people with certain severe psychiatric
diagnoses and functional limitations, but the complex needs of people with IDD and/or ASD are beyond the resources of the mental health system and usually span across multiple systems of care.

This complex population often becomes frequent users of local public health systems, most notably emergency rooms and psychiatric inpatient units, and is ultimately at risk for institutional placement in state-supported living centers. The goals of this project are to avert potentially avoidable inpatient admission and readmissions in restrictive settings, including state-supported living centers and acute care psychiatric units; to avert disruptive and deleterious events such as criminal justice system involvement and institutionalization; to promote wellness and adherence to medication and other treatments; and to promote recovery in the community.

**Regional Goals/Community Needs:**
This project directly meets broad goals identified by the regional needs assessment. First, it improves on existing programs and infrastructure by filling a void that is unmet by existing psychiatric outpatient clinics and psychiatric emergency services. Second, it increases access to specialty care services by providing treatment in an additional Houston location. The program also offers a preventative, patient-centered approach that provides brief psychiatric care to those in urgent need. The proposed program will also complement the regional need to develop a culture of “best practices,” whereby the patient/consumer plays a more active role as a stakeholder by completing consumer satisfaction surveys.

**Challenges:**
Families with complex problems often have multiple needs, which may include caregivers who have mental illness. This project will need to work closely with other programs that provide treatment of illness to individual family members when identified, since therapy for specific caregivers with mental illness may be beyond the scope of the team’s services. Referral, linkage, and education and support for family members can fall within the team’s scope, which means some assistance may be facilitated, but direct treatment of family members is not part of the proposed project. Additionally, although these individuals and families have needs that span across multiple systems of care, not all systems are skilled in, or accepting of, the target population. The project will need to build bridges with those systems or find alternatives that may be limited in our community.

**Five-year expected outcome(s):**
The hope is that by the end of the five-year DSRIP project, the proposed program will have established an approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient and family needs, improves health care outcomes and patient satisfaction, facilitates access to primary and specialty care services for the underserved population of people with IDD and/or ASD, and ensures that they receive the most appropriate care for their condition, regardless of where they live or their ability to pay. The project is expected to transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction, empowerment and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system. The number of individuals impacted is shown below, by DY:
These goals are consistent with the regional goals and community needs discussed elsewhere. Furthermore, the improvement metrics chosen for this project (I-2.1: The percent decrease in preventable admissions and readmissions to state supported living centers and I-5.1: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instrument, the Supports Intensity Scale for adults and TBD for children will determine the progress MHMRA is making to meet our stated goals.

**Starting Point/Baseline:**
Currently, MHMRA does not have a dedicated team as proposed.

**Rationale:**
Individuals with IDD and/or ASD exhibit deficits in adaptive behaviors as part of their diagnostic profile. When these deficits develop into behavioral excesses resulting from learned contingencies or co-occurring illnesses (as they do in about 33% of people with IDD and/or ASD), timely intervention is required to avoid costlier levels of care. These behavioral excesses place extreme pressures on families who do not know where to find the few resources available to assist them in times of need. Families may reach out for help and, finding none, decide that out of home placement is the only option. Such placements are expensive and burden the public system; moreover, they are almost always avoidable.

In-home services are beneficial for people with IDD and/or ASD because behavior change can be effected in the setting where those behaviors are exhibited. This population is known for difficulties in generalizing treatment benefits; i.e., learning a skill in one setting and transferring it without additional training into another setting. In-home services, in contrast with clinic-based services, provide onsite skills training and reduce the need for generalization training. Additionally, individuals and families can experience success within their natural environment, thus reducing the temptation to seek alternative placements. Once behavioral stability is achieved, treatment benefits can be supported by linking the person and family to mainstream services such as specialized therapies, employment services, and other supports that allow increased independence and promote a sense of self-efficacy.

Treating the person with IDD and/or ASD addresses only some of the presenting problems. Families who have a loved one with a developmental delay and severe behavior problems often report elevated levels of stress, depression, and marital discord. These families are further impacted by enforced unemployment when one parent must remain at home to manage the person with IDD or ASD, which adds financial hardships to the family’s stressors. Notably, family therapy is not supported in the array of services for people with IDD and/or ASD, though it is recognized as an important factor for promoting resilience and creating a strong foundation in which change for the better can occur. The project will measure family/caregiver stress; the hypothesis is that a reduction in stress levels will be observed as resources are put into place and the family regains control over their loved one’s situation.
The In-Home Team is designed to provide behavioral interventions, linkage to community options, and family supports to individuals with IDD and/or ASD who have serious behavior problems. These individuals are not supported by the network of private Medicaid waiver providers and are therefore at a high risk for institutional referral. In-Home Team interventions focus on decreasing problem behaviors, thereby enabling individuals to remain in their homes and avoid more expensive and restrictive placements. Additionally, recognizing that the family must also be stable and healthy for the child to improve, family counseling and linkage and referral to community services is rolled into the service. This service is not included in the array of currently funded IDD services. Harris County also has approximately 106,494 residents with an intellectual and developmental disability; 24,000 with autism spectrum disorder; and of people in these groups, 38,700 are dually diagnosed with co-occurring mental illness. By providing timely intervention and linkage to community resources, individuals can be empowered to live independently or with their families, with minimal intrusion and maximum clinical benefit.

**Project Components:**
In order to develop such a program, the following option and core components were chosen:

2.13.1 Expand the number of community based settings where behavioral health services may be delivered in underserved areas:

a. MHMRA will continue to assess the size, characteristics, and needs of the target population through ongoing work with patients and families/caregivers.

b. MHMRA will continue to review literature and its experience with IDD/ASD populations to determine community-based interventions that are effective in averting negative outcomes such as repeated or extended inpatient psychiatric hospitalization, decreased mental and physical functional status, nursing facility admission, forensic encounters; and in promoting correspondingly positive health and social outcomes or quality of life.

c. MHMRA will utilize a team approach involving clinical and program staff and the newly formed Outcome Management Department and the Quality Management Department, to develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.

d. MHMRA will design models which include an appropriate range of community-based services and residential supports.

e. MHMRA will assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.

**Unique Community Need Identification numbers:**
Enhancing the Intensity of Outpatient Behavioral Health Services will address the following community needs: CN3-Insufficient Access to Behavioral Health; CN18- Integrated Care for Behavioral Health; CN20- Improved Access to Patient Education.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** Currently, there is no team dedicated to this service, although one is needed due to the insufficient capacity to provide needed services. The proposed project is intended to close these gaps in the service continuum.
**Related Category 3 Outcome Measure(s):**
IT-6.1 Percent improvement over baseline of patient satisfaction scores

**Reasons/rationale for selecting the outcome measure:** Measurement of patient satisfaction is a key indicator of patient-centered care and has been targeted as a quality indicator by national organizations dedicated to improvement in patient outcomes, *e.g.*, the National Council for Quality Assurance. Furthermore, if patients and their family are satisfied with services, then we can assume they are being provided for adequately. On the other hand, if patients are dissatisfied, having an avenue to express their concerns is important for patient empowerment.

IT-10.2 Activities of Daily Living

**Reasons/rationale for selecting the outcome measure:** Although satisfaction with functional status will be included in the patient satisfaction measure, and additional standardized instrument will be used to measure change objectively in this area. It is hypothesized that true improvement will be reflected in increased independence and decreased reliance on external supports. For adults, the project will measure these changes by using the Supports Intensity Scale (SIS), a tool developed and normed for the target population, and designed to evaluate the practical supports needed by a person with IDD/ASD. It is hypothesized that the need for supports will decrease from intake to discharge from services, as the intervention team’s efforts promote independence in the individual and his/her family or other support systems. The SIS is in the process of being normed on children and may not be available for the proposed project; other tools that assess level of need will also be investigated, and the one that is most appropriate for the target population will be selected.

**Relationship to Other Projects:** The proposed project has activities related to the following MHMRA proposals: 1.9 Expand Specialty Care Capacity: IDD Specialized Treatment and Rehabilitative Services (STARS) and 2.12 Implement/Expand Care Transitions Programs: IDD/ASD Inpatient Consultation and Liaison Service

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

**Project Valuation:**
In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

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

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature.

Research has shown that care-givers of individuals with IDD/ASD are at risk for mental health problems of their own due to stress (Cummins, 2001). Past research has also linked aggression to parent distress (Chadwick, Beecham, Piroth, Bernard & Taylor, 2002; Douma, Dekker & Koot, 2006; Plant & Sanders, 2007; Weiss, Lunskey, Gracey, Canrinus & Morris, 2009). Parent training has been an effective tool to reduce stress related to caring for IDD/ASD individual, better ability to manage behaviors in the home and improved use of resources such as reduced ER visits (Hassiotis, Robotham, Canagasabey, Marston, Thomas & King, 2012). Through parent intervention, additional value can be gained. Using Ganz estimated indirect costs to family members caring for an individual with IDD/ASD at the average age of the patient (13 years old), the yearly costs were $9613.25.

\[
\text{100 (patients served)} \times \$9613.25 (\text{annual indirect family costs}) = \$961,325 \text{ Cost Savings: Indirect Family}
\]

**Summary and Total Valuation:**
This valuation analysis shows that the intervention will have a positive value for participants. The combined value is $961,325 per 100 people served.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1** [P-1]: Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources.  
**Metric 1** [P-1.1]: Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization  
Data Source: MHMRA Records and public inpatient psychiatric records, possibly jail records  
**Goal**: Complete literature review

**Milestone 2** [P-4]: Evaluate and continuously improve interventions  
**Metric 1** [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles  
Data Source: Written Quarterly Reports  
**Goal**: incorporate the proposed project into the current biweekly review

**Milestone 3** [P-5]: Design community-based specialized interventions for target populations.  
**Metric 1** [P-5.1]: Project plans which are based on evidence / experience and which address the project goals  
Data Source: Written Plans  
**Goal**: Complete a resource library of services for linking participating patients and will maintain this list as services develop.

**Milestone 4** [P-6]: State Supported Living Center (SSLC) Admissions  
**Metric 1** [I-2.1]: X% decrease in preventable admissions and readmissions to state supported living centers;  
Data Source: MHMRA and DADS reports  
**Goal**: 10% decrease in admissions

**Milestone 5** Estimated Incentive Payment: $332,706.35

**Milestone 5** [P-2]: Design community-based specialized interventions for target populations.  
**Metric 1** [P-2.1]: Project plans which are based on evidence / experience and which address the project goals  
Data Source: Written Plans  
**Goal**: Complete a resource library of services for linking participating patients and will maintain this list as services develop.

**Milestone 6** [P-3]: Enroll and serve individuals with IDD/ASD and targeted behavioral needs  
**Metric 1** [P-3.1]: Number of targeted individuals enrolled / served in the project.  
Data: Project documentation  
**Goals**: Enroll and serve 80 individuals/families by the end of Yr

**Milestone 7** Estimated Incentive Payment: $600,058.27

**Milestone 7** [I-2]: State Supported Living Center (SSLC) Admissions  
**Metric 1** [I-2.1]: X% decrease in preventable admissions and readmissions to state supported living centers;  
Data Source: MHMRA and DADS reports  
**Goal**: 5% decrease in admissions

**Milestone 8** Estimated Incentive Payment: $577,714.05

**Milestone 8** [I-2]: State Supported Living Center Admissions  
**Metric 1** [I-2.1]: X% decrease in preventable admissions and readmissions to state supported living centers  
Data Source: MHMRA and DADS reports  
**Goal**: 10% decrease in admissions

**Milestone 9** Estimated Incentive Payment: $370,559.48

**Milestone 9** [I-2]: State Supported Living Center (SSLC) Admissions  
**Metric 1** [I-2.1]: X% decrease in preventable admissions and readmissions to state supported living centers;  
Data Source: MHMRA and DADS reports  
**Goal**: 5% decrease in admissions

**Milestone 10** Estimated Incentive Payment: $332,706.35

**Milestone 10** Family/Caregiver Stress  
**Metric 1**: Decrease in reported stress within family/caregiver system as measured on a standardized tool TBD  
**Goal**: 5% decrease in reported stress

**Milestone 11** Estimated Incentive Payment: $600,058.27

**Milestone 11** [I-2]: State Supported Living Center (SSLC) Admissions  
**Metric 1** [I-2.1]: X% decrease in preventable admissions and readmissions to state supported living centers;  
Data Source: MHMRA and DADS reports  
**Goal**: 5% decrease in admissions

**Milestone 12** Estimated Incentive Payment: $577,714.05

**Milestone 12** [I-2]: State Supported Living Center Admissions  
**Metric 1** [I-2.1]: X% decrease in preventable admissions and readmissions to state supported living centers  
Data Source: MHMRA and DADS reports  
**Goal**: 10% decrease in admissions

**Milestone 13** Estimated Incentive Payment: $370,559.48

**Milestone 13** Family/Caregiver Stress  
**Metric 1**: Decrease in reported stress within family/caregiver system as measured on a standardized tool TBD  
**Goal**: 5% decrease in reported stress

**Milestone 14** Estimated Incentive Payment: $332,706.35

**Milestone 14** [I-2]: State Supported Living Center Admissions  
**Metric 1** [I-2.1]: X% decrease in preventable admissions and readmissions to state supported living centers  
Data Source: MHMRA and DADS reports  
**Goal**: 10% decrease in admissions
<table>
<thead>
<tr>
<th>Unique Identifier: 113180703.2.8</th>
<th>RHP PP Reference Number: 2.13.1</th>
<th>Project Components: A-E</th>
<th>IDD/ASD WRAP AROUND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td></td>
<td>113180703</td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient satisfaction</td>
<td>Unique Category 3 Project ID: 113180703.3.16 113180703.37</td>
<td>IT-6.1  IT-10.2</td>
<td></td>
</tr>
<tr>
<td>Activities of Daily living</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Year</th>
<th>Year</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 3 [P-5]:</strong></td>
<td><strong>Milestone 7 [P-5]:</strong></td>
<td><strong>Milestone 12:</strong></td>
<td><strong>Milestone 15:</strong></td>
</tr>
<tr>
<td>Participate in at least</td>
<td>Participate in at least</td>
<td>Enroll and serve</td>
<td>Enroll and serve</td>
</tr>
<tr>
<td>bi-weekly interactions</td>
<td>bi-weekly interactions</td>
<td>individuals</td>
<td>individuals</td>
</tr>
<tr>
<td>with other providers</td>
<td>with other providers</td>
<td>Metric 1: Targeted</td>
<td>Metric 1: Targeted</td>
</tr>
<tr>
<td>and the RHP to promote</td>
<td>and the RHP to promote</td>
<td>population reached</td>
<td>population reached</td>
</tr>
<tr>
<td>collaborative learning</td>
<td>collaborative learning</td>
<td>Data Source: MHMRA and</td>
<td>Data Source: MHMRA and</td>
</tr>
<tr>
<td>around shared or</td>
<td>around shared or</td>
<td>DADS reports</td>
<td>DADS reports</td>
</tr>
<tr>
<td>similar projects.</td>
<td>similar projects.</td>
<td>Goal: 15% increase over</td>
<td>Goal: 25% increase over</td>
</tr>
<tr>
<td><strong>Metric 1 [P-5.1]:</strong></td>
<td><strong>Metric 1 [P-5.1]:</strong></td>
<td>baseline</td>
<td>baseline</td>
</tr>
<tr>
<td>Number of bi-</td>
<td>Number of bi-</td>
<td>Numerator: Number of</td>
<td>Numerator: Number of</td>
</tr>
<tr>
<td>weekly meetings,</td>
<td>weekly meetings,</td>
<td>individuals served over</td>
<td>individuals served over</td>
</tr>
<tr>
<td>conference calls, or</td>
<td>conference calls, or</td>
<td>baseline</td>
<td>baseline</td>
</tr>
<tr>
<td>webinars organized by</td>
<td>webinars organized by</td>
<td>Denominator: DY3</td>
<td>Denominator: DY3</td>
</tr>
<tr>
<td>the RHP that the provider</td>
<td>the RHP that the provider</td>
<td>baseline</td>
<td>baseline</td>
</tr>
<tr>
<td>participated in.</td>
<td>participated in.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: written</td>
<td>Data Source: written</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bi-weekly documentation</td>
<td>bi-weekly documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 2 [P-5.2]:</strong></td>
<td><strong>Metric 2 [P-5.2]:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Share challenges and</td>
<td>Share challenges and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>solutions successfully</td>
<td>solutions successfully</td>
<td></td>
<td></td>
</tr>
<tr>
<td>during this bi-weekly</td>
<td>during this bi-weekly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>interaction.</td>
<td>interaction.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Attend and</td>
<td>Goal: Attend and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>participate in meetings</td>
<td>participate in meetings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Written</td>
<td>Data Source: Written</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation</td>
<td>Documentation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Milestone 3 Estimated Incentive Payment: $370,559.48 | Milestone 7 Estimated Incentive Payment: $332,706.35 | Milestone 12 Estimated Incentive Payment: $600,058.27 | Milestone 15 Estimated Incentive Payment: $577,714.05 |

| Milestone 6 Estimated Incentive Payment: $332,706.35 | Milestone 11 Estimated Incentive Payment: $600,058.27 | Milestone 14 Estimated Incentive Payment: $577,714.05 | |

| Milestone 12 Estimated Incentive Payment: $600,058.27 | Milestone 15 Estimated Incentive Payment: $577,714.05 | |

| Milestone 15 Estimated Incentive Payment: $577,714.05 | |

**Data Source:** Written Documentation
<table>
<thead>
<tr>
<th>Unique Identifier: 113180703.2.8</th>
<th>RHP PP Reference Number: 2.13.1</th>
<th>Project Components: A-E</th>
<th>IDD/ASD WRAP AROUND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td>[IT-6.1][IT-10.2]</td>
<td>113180703</td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td><strong>Unique Category 3 Project ID:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient satisfaction</td>
<td>113180703.3.16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities of Daily living</td>
<td>113180703.37</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 4 [P-7]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

**Metric 1 [P-7.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Metric 2 [P-7.2]:** Metric: Implement the raise the floor improvement initiatives established at the semiannual meeting.

Data Source: Documentation of raise the floor activities

**Milestone 8 [P-4]:** Evaluate and continuously improve interventions

**Metric 1 [P-4.1]:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles

Goal: The goal is to incorporate the proposed project into the current biweekly review processes

Data Source: Written Quarterly Reports

**Milestone 4 Estimated Incentive Payment:** $370,559.48

**Milestone 8 Estimated Incentive Payment:** $332,706.35

**Milestone 9 [P-7]:** Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

**Metric 1 [P-7.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Metric 2 [P-7.2]:** Implement the raise the floor improvement initiatives

Data Source: Written documentation

**Milestone 9 Estimated Incentive Payment:** $332,706.36

Regional Healthcare Partnership Plan

Region 3

1351
### Project Components: A-E

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $1,482,237.93</td>
<td>Year 3 Estimated Milestone Bundle Amount: $1,663,531.76</td>
<td>Year 4 Estimated Milestone Bundle Amount: $1,800,174.82</td>
<td>Year 5 Estimated Milestone Bundle Amount: $1,733,142.15</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $6,679,086.66
REFERENCES


2.17: DESIGN, IMPLEMENT, AND EVALUATE INTERVENTIONS TO IMPROVE CARE TRANSITIONS FROM THE INPATIENT SETTING FOR INDIVIDUALS WITH MENTAL HEALTH AND/OR SUBSTANCE ABUSE DISORDERS -- IDD/ASD INPATIENT CONSULTATION AND LIAISON SERVICE

RHP Project Number: 113180703.2.9  TPI: 113180703

Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received IDD services in FY12, such as those being proposed in this project, 34.1% were medically indigent and 57.1% had Medicaid.

Intervention(s): MHMRA proposes to expand and further develop the Inpatient Consultation and Liaison (C&L) team that provides consultation and services to patients suspected of Intellectual and Developmental Disabilities and Autism Spectrum Disorders (IDD and ASD) referred by attending physicians at the Harris County Psychiatric Center (HCPC); with subsequent expansion to provide similar services to other inpatient settings in Harris County.

Need for the project: Approximately 106,494 Harris county residents are diagnosed with an intellectual and developmental disability; 24,000 with autism spectrum disorder; and of people in these groups, 38,700 are dually diagnosed with co-occurring mental illness. When a person with a co-occurring condition requires hospitalization to stabilize symptoms of mental illness, they often encounter well-meaning clinicians who have limited exposure and experience in treating this population. This situation can be alleviated with specialized consultation by clinicians who are experts in ID/ASD and co-occurring mental illness. Not only would effective consultation include recommendations for inpatient treatment, but recommendations for effective discharge planning and care transition would be necessary to reduce preventable rehospitalizations.

Target population: Harris county residents with comorbid mental health and IDD/ASD issues presenting in psychiatric emergency services. It is anticipated that 70 individuals will be served by the program expansion.

Category 1 or 2 expected patient benefits: MHMRA expects a

- 75% increase in patients with customized care plans over DY3 baseline
- 50% increase in target inpatient population members who have been discharged and have received clinician follow-up calls to review treatment plans and assess compliance.

Category 3 outcomes: MHMRA expects to decrease admissions to state supported living facilities and state hospitals by 10% in DY5.
2.17: Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse Disorders -- IDD/ASD Inpatient Consultation and Liaison Service

**RHP Project ID:** 113180703.2.9

**Performing Provider / TPI:** Mental Health and Mental Retardation Authority of Harris County / 113180703

**Project Description:**

*The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to design, implement and evaluate an Inpatient Consultation and Liaison service for individuals with IDD/ASD.*

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves about 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received agency services in FY12, 60.0% were medically indigent and 32% had Medicaid. Of those who received IDD services, such as those being proposed in this project, 34.1% were medically indigent and 57.1% had Medicaid.

MHMRA proposes to expand and further develop the Inpatient Consultation and Liaison (C&L) team that provides consultation and services to patients suspected of Intellectual and Developmental Disabilities and Autism Spectrum Disorders (IDD and ASD) referred by attending physicians at the Harris County Psychiatric Center (HCPC); with subsequent expansion to provide similar services to other inpatient settings in Harris County. This model is intended to divert people with IDD/ASD from higher cost, inpatient placement and into local resources. Accordingly, this project meets the Delivery System Incentive Reform Payment (DSRIP) Pool 1115(a) waiver component 2.17 Establish improvements in care transition from the inpatient setting for individuals with mental health and / or substance abuse disorders.

**Goals:**

The goal of this project is to implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. By the end of year five, established protocols should result in a transformation of care that results in diversion of cases that do not need inpatient treatment, improved patient-specific inpatient protocols, and effective discharge and aftercare that promote continuity of treatment benefits.

**Regional Goals:**

By the end of the five-year DSRIP project, the proposed program will have established an approach to health care delivery that leverages and improves on existing programs and
infrastructure, is responsive to patient and family needs, improves health care outcomes and patient satisfaction, facilitates access to inpatient and outpatient specialty care services for the underserved population of people with IDD/ASD, to ensure that they receive the most appropriate care for their condition, regardless of where they live or their ability to pay. The project is expected to transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary re-hospitalizations, and builds on the accomplishments of our existing health care system.

Starting Point/Baseline:
Annually, the current, reduced HCPC Consultation and Liaison (C&L) team consults and assists an average of 110 unduplicated patients each year; however, an increase was noted in the past year, when the team was called to consult on 150 cases. With increased pressure upon state supported living centers to discharge residents into communities, combined with reduced state hospital and state supported living center beds, more cases may be anticipated. Fifty percent of the cases seen by the team are new to MHMRA and can be linked to community resources to minimize the likelihood of recurrent crises. The present team capacity, however, can only address a limited number of patients within HCPC and cannot extend beyond that facility, where additional needs exist. Furthermore, discharge planning is a difficult task without an established protocol that contains a decision tree for linking to appropriate community options. The proposed project is intended to close these gaps.

The following table illustrates the number of patients who are expected to benefit from the development of the protocols and services described in the proposal.

<table>
<thead>
<tr>
<th></th>
<th>DY2</th>
<th>DY3</th>
<th>DY4</th>
<th>DY5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>40</td>
<td>60</td>
<td>70</td>
</tr>
</tbody>
</table>

Rationale:
The existence of co-occurring mental illness in people with IDD/ASD has been widely recognized; however, treatment of psychiatric conditions in this population is still in its infancy, with unremarkable treatment outcomes. Poor treatment outcomes include more frequent psychiatric hospitalizations; longer admissions and later identification in the psychiatric event, resulting in higher levels of care. Furthermore, studies examining the treatment of co-occurring disorders report that mental health clinicians, including psychiatrists, psychologists, social workers, nurses and other disciplines, are rarely formally trained to treat people with IDD/ASD and MI. Lack of exposure to people with developmental disabilities causes clinicians to shy away from these patients; and when they do become involved, they intervene later in the course of the disease process and tend to use medication for sedating purposes and not in accordance with the person's mental illness.

Texas has documented similar concerns. In May 2011, the directors of IDD programs in mental health authorities across Texas were queried about the resources in their areas for responding to behavioral crises. Across the state they reported a lack of skilled clinicians and also noted psychiatric hospitals often refused inpatient services to individuals with co-morbid IDD and...
psychiatric illness in crisis because they lacked expertise in the population. Conversely, when admitted, they had extended inpatient stays with little improvement in behavioral functioning. With no other alternative in Texas, communities turn to institutional care in State Supported Living Centers (formerly called State Schools) to manage and treat these individuals. This is an expensive choice. The current annual cost for a person with IDD in a state supported living center is $177,624.

Additionally, Harris County has documented a similar need among this population. Approximately 106,494 Harris county residents are diagnosed with an intellectual and developmental disability; 24,000 with autism spectrum disorder; and of people in these groups, 38,700 are dually diagnosed with co-occurring mental illness. When a person with a co-occurring condition requires hospitalization to stabilize symptoms of mental illness, they often encounter well-meaning clinicians who have limited exposure and experience in treating this population. This situation can be alleviated with specialized consultation by clinicians who are experts in ID/ASD and co-occurring mental illness. Not only would effective consultation include recommendations for inpatient treatment, but recommendations for effective discharge planning and care transition would be necessary to reduce preventable re-hospitalizations.

Care transitions refer to the movement of patients from one health care provider or setting to another. When a patient's transition is less than optimal, the repercussions can be far reaching (e.g., hospital readmission, an adverse medical event, and even mortality). Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities. People with IDD/ASD and co-occurring mental illness are high-risk patients who often have multiple chronic diseases. The implementation of effective care transitions requires practitioners to learn and develop effective ways to successfully manage one disease in order to effectively manage the complexity of multiple diseases (Rittenhouse et al., 2010).
transitions typically results in patients with serious conditions falling through the cracks, which may lead to otherwise preventable hospital readmission (Parry et al., 2003).

The model MHMRA is proposing to implement has been tested previously with excellent results. In 1996, MHMRA assigned a team consisting of a psychiatrist, a psychologist, a social worker and a case worker to work within (HCPC) to identify people with IDD/ASD who were hospitalized with co-occurring mental illness and to consult as needed with the hospital’s attending physician. When the team was first developed, the Multiple Disabilities Unit (MDU) at Rusk State Hospital housed, on average, 48 Harris County residents per day. With successful diversion by the team, within two years, the average daily census in the MDU from Harris County was reduced to five. It fell further to approximately two, until the MDU was closed for lack of use. This process is illustrated below.

The team was successful at reducing institutional placement, as indicated in the graph below, but over time, with successive funding reductions, the team, was equally reduced and lost state funding. By developing the team fully and expanding its scope, it is anticipated that the diversion of hospital patients into community options will represent substantial savings.

**Challenges:** One of the challenges will be hiring and training the appropriate level of staff to provide increased access and service to the targeted population. The proposed project will develop the workforce of clinicians who are competent to work with the target population and are comfortable doing so. MHMRA will continue to build upon existing partnerships with local universities, medical schools, public and private Medicaid providers and other agencies to develop clinicians who are skilled and willing to treat people with IDD/ASD, thereby growing an ever-expanding pool of competent community providers.

**Project Components:**
In order to develop such a program, option 2.17.1 was selected. The status of each component is noted, if that activity is currently underway:

a) MHMRA will develop a cross-continuum team comprised of clinical and administrative representatives from acute care; skilled nursing; ambulatory care; health centers; HCS, ICF-ID and other Medicaid waiver providers; and home care providers of care to people with IDD/ASD.

b) MHMRA will conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool (e.g. the Institute for Healthcare Improvement’s (IHI) State Action on Avoidable Re-hospitalizations (STAAR) tool) and patient interviews. A literature review has been started to help identify evidence-based factors, but patient and other stakeholder input will be the critical for this component.

c) MHMRA will identify baseline mental health and substance abuse conditions at high risk for readmissions in the target population, (example include schizophrenia, bipolar disorder, major depressive disorder, chemical dependency)

d) MHMRA will identify and prioritize evidence-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions with specific attention to models that include patients with IDD/ASD.

e) MHMRA will review best practices for improving care transitions from a range of
evidence-based or evidence-informed models

f) MHMRA will implement discharge planning program and post discharge support program. Pilot processes are being sampled and will contribute to lessons learned as this important component evolves

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

Community Needs:
The Consultation and Liaison program will address the following community needs:

- CN2-Insufficient Access to Behavioral Health
- CN5- Integrated Care for Behavioral Health
- CN12- Improved Access to Patient Education
- CN14-Reduction of ER Services

The improvement metrics chosen for this project was a measure of those receiving the service (I-11: Number over time of those patients in target population receiving standardized, evidence-based interventions). Determining the number of patients served will help determine the progress MHMRA is making toward our stated goals. focus on the development and implementation of transition protocols and post-discharge follow-up to promote behavioral stability after discharge and reduce the likelihood of readmission or admission into costlier state institutional care.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: Currently, the team capacity is insufficient for the population in need of consultation and liaison services. Furthermore, discharge planning is a difficult task without an established protocol that contains a decision tree for linking to appropriate community options. The proposed project is intended to close these gaps in the service continuum.

Related Category 3 Outcome Measure(s):
IT-2.13 Other Admissions Rate: Rate of Admission into State Supported Institutional Care
IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate

Reasons/rationale for selecting the outcome measures:
The goal of inpatient psychiatric/behavioral care is to stabilize an individual’s condition and facilitate successful reintegration into everyday life. For people with IDD/ASD and co-occurring mental illness, the supports to promote this goal must be coordinated by people who are knowledgeable in developmental disabilities, and often guided after discharge to help the person whose cognitive/intellectual abilities are often barriers to following through with aftercare. The lack of coordinated post-discharge plans and follow-through often result in re-hospitalizations or admission to very expensive and restrictive institutional care. The proposed model is intended to reduce the costs of healthcare by preventing these outcomes and demonstrating these benefits through the selected Category 3 measures.
**Relationship to Other Projects:** At this time there is not enough information available from the RHP to describe how this project may or may not be related to other RHP DSRIP proposals; however, the proposed project has activities related to the following MHMRA proposals: IDD Specialized Treatment and Rehabilitative Services (STARS) and IDD/ASD Wrap-around and In-home Services.

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

**Project Valuation:**
In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research) and additional information is reported on potential, future costs saved. The value of each of the above delivery systems will be reviewed separately. The total valuation will be the sum of the individual component valuations.

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

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

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. The number of life-years added is based on a review of the scientific literature.

**Cost-Utility Analysis:**
After an extensive review of the literature, no studies were located that contained an estimate of QALYs gained due to this intervention.

**Cost-Effectiveness and Cost Savings:**
Cost-effectiveness analysis (CEA) is similar to CUA, except that the cost averted is compared to a common health outcome, such as cost per depression-free day. We did identify a benefit-cost study that is related.

After MHMRA of Harris County implemented this service in 1999, the state hospitalization rate was reduced by 97% for the following fiscal year. In the four years prior to the implementation of the consultation and liaison services in 1999, about 255 or 55.69% of those admitted to HCPC had an IDD diagnosis. Of the 255 people admitted to HCPC who had an IDD diagnosis between 1995 and 1998, 44.31% were subsequently sent to a state hospital, an average of 28.25 individuals per year.

The average cost of the state hospital was about $400 per day with an average length of stay of 197.49 days. These figures indicate that a savings of at least $41,622.99 could be expected if the program served 100 individuals. However, because these figures were from 1999 and the state hospital unit has since closed, we will not include this cost savings estimate in the final valuation amount.

Research has shown that care-givers of individuals with IDD/ASD are at risk for mental health problems of their own due to stress (Cummins, 2001). Past research has also linked aggression to parent distress (Chadwick, Beecham, Piroth, Bernard & Taylor, 2002; Douma, Dekker & Koot, 2006; Plant & Sanders, 2007; Weiss, Lunsky, Gracey, Canrinus & Morris, 2009). Parent training has been an effective tool to reduce stress related to caring for IDD/ASD individual, better ability to manage behaviors in the home and improved use of resources such as reduced ER visits (Hassiotis, Robotham, Canagasabey, Marston, Thomas & King, 2012). Through parent intervention, additional value can be gained. Using Ganz estimated indirect costs to family members caring for an individual with IDD/ASD at the average age of admission to HCPC (31 years) the yearly costs were estimated to be $8939.25.

\[
\begin{align*}
100 \text{ (patients served)} & \times $8939.25 \text{ (annual indirect family costs)} \\
= $893,925 & \text{ Cost Savings: Indirect Family}
\end{align*}
\]

**Summary and Total Valuation:** This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). The total valuation for this program is **$893,925 per year.**
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Milestone 1 P-2.** Milestone: Collect information and /or analyze data on factors contributing to preventable readmissions within 30 days. Goal: Identify key factors to preventable 30-d readmissions  
Metrics:  
Metric 1: P-2.1. Conduct a minimum of 10 interviews with patient/family members regarding an occurrence of a preventable 30 day hospital readmission  
Metric 2: P-2.2. Review interview data conducted by multidisciplinary team  
Metric 3 P-2.4. Develop an electronic report on readmission data  
Metric 4: P-2.5. Chart review Reports  
Metric 5: P-2.6. Determine baseline metric for all cause 30 day readmission  
Metric 6: P-2.7. Identification of key factors that increase the likelihood of preventable 30 day readmissions for individuals with mental health and substance use disorders  
a. Data Sources: Documented summary of interview results; minutes of meetings analyzing interview results; report on readmission data; report listing key contributing factors | **Milestone 5 I-10.** Milestone: Develop plan(s) for a (1) hospital care transition process and (2) community-based aftercare / follow-up program for high-risk patients.  
Metric 1: I-10.2. Transition Process Improvement Plan  
Metric 2: I-10.3. Community-based aftercare plan  
a. Internal hospital records/documentation | **Milestone 9 I-38: Customized Care Plans**  
**Metric 1:** X% increase in High Risk Patients who are discharged with customized care plans  
Goal: 50% increase in patients with customized care plans over DY3 baseline  
  a. Numerator: The number of high risk patients discharged from inpatient settings who are provided with customized care plans upon discharge  
  b. Denominator: The number of high risk patients discharged from inpatient settings within the RHP Project Site  
  c. Data Source: Medical Records; Project Data; Clinician Logs; Patient / Family Satisfaction Survey | **Milestone 11 I-38: Customized Care Plans**  
**Metric 1:** X% increase in High Risk Patients who are discharged with customized care plans  
Goal: 75% increase in patients with customized care plans over DY3 baseline  
  a. Numerator: The number of high risk patients discharged from inpatient settings who are provided with customized care plans upon discharge  
  b. Denominator: The number of high risk patients discharged from inpatient settings within the RHP Project Site  
  c. Data Source: Medical Records; Project Data; Clinician Logs; Patient / Family Satisfaction Survey |
<p>| Mental Health and Mental Retardation Authority of Harris County | | | |</p>
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1** Estimated Incentive Payment: $370,559.4

**Milestone 5** Estimated Incentive Payment: $415,882.94

**Milestone 9** Estimated Incentive Payment: $600,058.27

**Milestone 11** Estimated Incentive Payment: $577,714.05

**Milestone 2** [P-1.] Establish Task Force or Team to support or lead project.

**Metric 1:** P-1.1. Establishment of Task Force or Team

Goal: Establish core team with representatives from key stakeholder entities

Data Source: Staffing and implementation plan.

**Milestone 6** P-11. Milestone: Evaluate and continuously improve care transitions programs

Metric 1: P-11.1. Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles

a. Project reports include examples of how real-time data is used for rapid cycle improvement to guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts, monthly dashboards with data on readmissions, and feedback from patients to drive improvement)

**Milestone 10** [I-40]: Assessment and Follow-up

**Metric 1** [I-40.1]: X% increase in target inpatient population members who have been discharged and have received clinician follow-up calls to review treatment plans and assess compliance.

Goal: 25% increase in patients contacted

a. Numerator: The number of patients in the target population discharged from inpatient settings who have received follow-up contact (two attempts) to review treatment plans and assess compliance.

b. Denominator: The number of patients in the target population discharged from inpatient settings

c. Data Source: Medical Records; Project Data; Clinician Logs

**Milestone 12** [I-40]: Assessment and Follow-up

**Metric 1** [I-40.1]: X% increase in target inpatient population members who have been discharged and have received clinician follow-up calls to review treatment plans and assess compliance.

Goal: 50% increase in patients contacted

a. Numerator: The number of patients in the target population discharged from inpatient settings who have received follow-up contact (two attempts) to review treatment plans and assess compliance.

b. Denominator: The number of patients in the target population discharged from inpatient settings

c. Data Source: Medical Records; Project Data; Clinician Logs
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 2</strong> Estimated Incentive Payment: $370,559.48</td>
<td><strong>Milestone 6</strong> Estimated Incentive Payment: $415,882.94</td>
<td><strong>Milestone 10</strong> Estimated Incentive Payment: $600,058.27</td>
<td><strong>Milestone 12</strong> Estimated Incentive Payment: $577,714.05</td>
</tr>
<tr>
<td><strong>Milestone 3</strong> [P-10]: Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects</td>
<td><strong>Milestone 7</strong> [P-10]: Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-10.1]: Number of bi-weekly RHP meetings MHMRA participated in Data Source: Written Documentation</td>
<td><strong>Metric 1</strong> [P-10.1]: Number of bi-weekly RHP meetings MHMRA participated in Data Source: Written Documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 2</strong> [P-10.2]: Share challenges and solutions successfully during this bi-weekly interaction Data Source: Written Documentation</td>
<td><strong>Metric 2</strong> [P-10.2]: Share challenges and solutions successfully during this bi-weekly interaction Data Source: Written Documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3 Estimated Incentive Payment: $370,559.48</strong></td>
<td><strong>Milestone 7 Estimated Incentive Payment: $415,882.94</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unique Identifier: 113180703.2.9</td>
<td>RHP PP Reference Number: 2.17.2</td>
<td>Project Components: A-G</td>
<td>IDD/ASD INPATIENT CONSULTATION AND LIAISON SERVICE</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Mental Health and Mental Retardation Authority of Harris County</td>
<td>113180703</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Related Category 3 Outcome Measure(s):**
- 113180703.17
- 113180703.3.38

**Year 2** (10/1/2012 – 9/30/2013)
- **Milestone 4 [P-12]:** Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects
  - **Metric 1 [P-12.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP
  - **Metric 2 [P-12.2]:** Implement the “raise the floor” improvement initiatives established at the semiannual meeting
  - Data Source: Written documentation of meetings

**Year 3** (10/1/2013 – 9/30/2014)
- **Milestone 8 [P-12]:** Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects
  - **Metric 1 [P-12.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP
  - **Metric 2 [P-12.2]:** Implement the “raise the floor” improvement initiatives established at the semiannual meeting.
  - Data Source: Written documentation of meetings

**Year 4** (10/1/2014 – 9/30/2015)

**Year 5** (10/1/2015 – 9/30/2016)

**Milestone 4 Estimated Incentive Payment:** $370,559.48

**Milestone 8 Estimated Incentive Payment:** $415,882.94

**Year 2 Est. Bundle Amount:** $1,482,237.93

**Year 3 Est. Bundle Amount:** $1,663,531.76

**Year 4 Est. Bundle Amount:** $1,800,174.82

**Year 5 Est. Bundle Amount:** $1,733,142.15

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $6,679,086.65
REFERENCES


Methodist Willowbrook Hospital

Pass 1
Project Option 2.17.1 - Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Implement Care Transition Coordination

**Unique Project ID#:** 140713201.2.1  
**Performing Provider Name / TPI:** Methodist Willowbrook Hospital / 140713201

**Project Summary:**

Provider:  
Methodist is a delivery system comprised of 4 community hospitals, 1 academic medical center in the Texas Medical Center, research institute, physician organization which employs 350 physicians and operates multiple ancillary care sites throughout the Houston metropolitan area. Methodist has 13,867 employees and has 4,185 associated physicians. Methodist has been recognized as the top hospital system in Houston & Texas by US News & World Report and honored as the top ranked healthcare provider to work for by Fortune Magazine. Methodist Willowbrook Hospital’s payor mix for Medicaid is 9.44% and 8.73% self pay.

Intervention(s):  
By facilitating effective transitions of care to behavioral health and primary care through locations within Harris County including HARRIS HEALTH SYSTEM, MHMRA, private physicians, and SJMH Family Medicine Residency physicians we seek to help patients navigate a complicated health-care landscape, participate in mental health choices, increase their self-efficacy, provide better quality of life and prevent readmissions and prevent adverse outcomes of incarceration, chemical dependency or suicide. Outpatient Service Availability is limited, and so we hope to leverage the community mental health workers to connect and encourage care within existing primary care and mental health resources. The program will advocate primary care expansion for mental health, through the use of treatment algorithms and perhaps by embedding counselors within a primary practice who could bill “incident to” for supervised service.

Target Population:  
About 140,000 adults in Harris County suffer from severe mental illness, while almost half of these adults had no access to treatment from the public or private health system. Our target population is defined as those individuals who suffer from any behavioral health related condition and who are seeking care in our facilities, more specifically those who are covered by Medicaid or without insurance coverage. At Methodist Willowbrook Hospital we serve those with behavioral health as detailed below:

<table>
<thead>
<tr>
<th>Total ED Visits - Self Pay &amp; Medicaid</th>
<th>22,059</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total ED Visits - Behavioral Health - Self Pay &amp; Medicaid</td>
<td>760</td>
</tr>
<tr>
<td>Total ED Admissions - Self Pay &amp; Medicaid</td>
<td>4,154</td>
</tr>
<tr>
<td>Total ED Admissions - Behavioral Health - Self Pay &amp; Medicaid</td>
<td>88</td>
</tr>
<tr>
<td>Total IP Admissions - Self Pay &amp; Medicaid</td>
<td>3,326</td>
</tr>
<tr>
<td>Total IP Admissions - Behavioral Health - Self Pay &amp; Medicaid</td>
<td>18</td>
</tr>
</tbody>
</table>
Category 1 or 2 expected patient benefits:
Our project will include a number program innovation and redesign efforts. These include ensuring we have recruiting qualified people to intervene and guide care, educate staff, identify community partners, re-engineering our discharge planning process to ensure patients transition into the ambulatory care setting successfully, setting up care coordination protocols to make sure we identify patient accurately who need our assistance and following our system’s CQI efforts of plan, do, check and act to ensure we’re achieving our expected outcomes for this target population. It is our goal to impact an estimated 50% of the patients who suffer from behavioral health issues and who visit our EDs and inpatient psychiatric units by year 3. That equates to over 380 total patients, over 200 who are covered by Medicaid or without coverage. We expect that number to increase to 60% in year 4 (over 600 total, over 300 Medicaid / self pay) and to 80% in year 5 (over 650, over 350 Medicaid / self pay). We also expect to see a 10% reduction in all-cause readmissions in year 4 and a 20% improvement in all-cause readmission in year 5 for our target population.

Category 3 outcomes: IT 1.18 Our goal is that in the first year we will coordinate care follow-up post discharge to 20% and increase this to 80% by year 5.
Project Option 2.17.1 - Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Implement Care Transition Coordination

Unique Project ID#: 140713201.2.1

Performing Provider Name / TPI: Methodist Willowbrook Hospital / 140713201

Project Description:

Preventing Behavioral Health Readmissions by Implementing Care Transition Coordination

According to Healthy Peoples 2010 Mental Illness is on par with heart disease and cancer as a cause for disability. 140,000 residents of Harris County suffer from Mental Illness.¹ Many have no access to treatment from the public or private health system. Almost 20,000 youths in Harris County are in need of treatment while only 24% of cases were addressed.²

Currently in Harris County there are limited locations for follow-up mental health care services. The MHMRA services are provided through an office in Pasadena or League City, which is more than 30-45 minutes away and many patients have limited transportation and other barriers to follow up mental health care. Care can be received at the Harris Health System clinic in Baytown where existing patients have access to a visiting Psychiatrist on site 1 half-day per week. This same scenario of limited facilities and physicians to provide ongoing chronic behavioral health care services plays itself out in Central and Northwest Harris County.

There are many barriers to effective mental health care provision. These can be grouped as patient factors, physician factors and system factors. Primary care and primary care psychiatry working together are necessary to address the care of affective and other mental illnesses.iii The intervention proposed will involve the use of community mental health workers with Behavioral Health Education who can coordinate the care of adult patients through the transition from inpatient care to outpatient levels of care including both mental health and primary care follow up. It will also include promoting and monitoring attendance at community settings such as chemical dependency programs. The community mental health workers will be located at The Methodist Hospital, San Jacinto Methodist Hospital and Methodist Willowbrook Hospital and will receive their case load from hospital discharges, referred discharges from Harris Health System who reside in these communities, and referrals from the Emergency Department. The community mental health workers will have access to hospital medical records including discharge planning. Ideally the information from SJMH and Harris Health System may be available through shared information systems between EPIC software and Methodist IT platforms. This will involve a software program called Medicity, which is contained in Methodist Connect and Harris County Health Connect. It will also involve securing patient consent for this level of information exchange.

The community mental health worker will then follow recognized treatment protocols to query patient compliance with treatment and contact the primary care physician or mental health specialist. The care transition manager may refer to specialized disease management programs, such as those for alcohol or chemical dependency. To assist primary care physicians providing
mental health follow up, treatment algorithms can guide treatment selection and increased quality and consistency of treatment, provide better clinical outcomes, and more efficient use of health care resources. The care will be directed toward the use guidelines including the Texas Medication Algorithm Project, (TMAP). It will also include recommending sequenced care such as the Sequenced Treatment Alternatives to Relieve Depression, (STAR-D), which assist patients and clinicians implementing “next step” treatment options. It involves patient-choice and buy-in as well as use of patient-completed rating scales such as the “Quick Inventory for Depressive Symptoms” to monitor response to treatment and alert when urgent outpatient mental health care or crisis intervention is necessary. Objective measurements such as this can assist the transitions nurse in evaluating severity or priority.

By facilitating effective transitions of care to behavioral health and primary care through locations within Harris County including Harris Health System, MHMRA, private physicians, and SJMH Family Medicine Residency physicians we seek to help patients navigate a complicated health-care landscape, participate in mental health choices, increase their self-efficacy, provide better quality of life and prevent readmissions and prevent adverse outcomes of incarceration, chemical dependency or suicide.

The costs associated with this program will include IT costs, Space Costs and Salary Costs.

**Goals and Relationship to Regional Goals:**

This project meets the following regional goals:

This program would meet the following three regional health goals #1 by leveraging and improving on existing programs and infrastructure. #2 by increasing access to primary and specialty care services, with a focus on underserved and the Medicaid populations. It will ensure patients receive the most appropriate and accessible care for their condition, regardless of where they live or their ability to pay. #3 It will transform from disease-centered emergency room care to patient-centered preventive approach to behavioral health care. It also reduced duplication of uncoordinated services currently received from county and private health care.

**Challenges:**
- Recruitment of qualified community mental health workers
- Recruitment of psychiatrists & acute care nurse practitioners
- Patient compliance

**5-Year expected outcome for Performing Provider and Patient:**

Focused effort to transition patients from the acute and ED setting with behavioral health conditions will improve outcomes and reduce costs. We aim to reduce repeat admissions to our inpatient psychiatric units and reduce repeat emergency room visits from our targeted population. Patients will benefit from a more hands-on, compassionate and integrated care coordination system for behavioral healthcare. This should translate to a reduction of demand for incarcerated
patients with mental illness and an improvement in the daily productivity from those who benefit from our program.

**Starting Point/ Baseline:**

We can get a partial measure of the problem based on recent ED and inpatient admissions. To this we may add utilization at nearby facilities, but the data is not available at present. At San Jacinto Methodist Hospital in 2011 there were 443 ED admissions with a primary diagnosis of a Mental Health condition, (187 were self-pay and Medicaid) resulting in a financial loss of $119k. At The Methodist Hospital there were 612 ED admissions with a primary diagnosis of a Mental Health condition resulting in a loss of $1.154M. At Methodist Willowbrook Hospital there were 160 ED admissions with a primary diagnosis of a Mental Health condition resulting in a loss of $6k. This may be an underestimate since it only captures primary diagnoses. There were 709 behavioral health admissions, 296 of which were self-pay and Medicaid, for a net financial loss of $324k.

It is estimated that 30-50% are readmitted within a one-year period based on national literature. Outpatient Service Availability is limited, and so we hope to leverage the community mental health workers to connect and encourage care within existing primary care and mental health resources. The program could advocate primary care expansion for mental health, through the use of treatment algorithms and perhaps by embedding counselors within a primary practice who could bill “incident to” for supervised service.

**Rationale:**

As referenced above, residents of Harris County have difficulty accessing mental health services.

The stated principles of the Harris County behavioral health system include quick, easy and convenient entry into services, full range of services and minimal financial barriers to necessary services. The principles promote recovery, continuity of care, family integration in care, evidence based care, and where possible co-location of behavioral health and general health care. HC Behavioral Health promotes stability of behavioral health conditions by decreasing relapse of mental illness and substance abuse.

A designated mental health professional provides oversight to the care-management team to provide this collaborative care. There are many examples of collaborative care management.

**Project Components:**

a. Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, ambulatory care, behavioral health and community-based non-medical supports

   a. We will develop a team of clinical leaders from various care settings to ensure care delivery is integrated and coordinated.

b. Conduct an analysis of the key drivers of 30-day hospital readmissions for behavioral health conditions using a chart review tool
a. We will review each chart and develop a trending report of complications from each patient who is readmitted. Our teams will use this information to ensure we are incorporating the appropriate care pathways while the patients are in the hospital and we will also make any changes to our discharge planning process as needed to reduce readmissions.

c. Identify baseline mental health and substance abuse conditions at high risk for readmissions
   a. We will begin with a retrospective review of all behavioral health related readmissions to identify trends. On a go-forward basis, we will review each chart and develop a trending report of complications from each patient who is readmitted. These reports will be updated to ensure we are identifying those patients who are at high risk for readmissions.

d. Review best practices for improving care transitions from a range of evidence-based or evidence-informed models
   a. Our teams will work collaboratively with other groups focused on reducing readmissions and incorporate their best practices to our patient population.

e. Identify and prioritize evidence-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions.
   a. Our teams will utilize the plan, do, check, act approach of continuous quality improvement for this project. Using this approach will ensure that we are identifying and prioritizing care transactions and reduce readmissions.

f. Implement two or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population.

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

The project will focus primarily on items b, c, d and e of the above listed components.

**Unique community need identification number the project addresses:**
CN.3 - Inadequate access to behavioral health care

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

This project represents the first time a focused, coordinated care navigation effort has been targeted at patients who suffer from behavioral health conditions. We feel that this project will significantly reduce unnecessary emergency department utilization & repeat admissions into inpatient psychiatric units.

Our hospital system receives monies from the CMS innovation grant program for 2 projects related to early recognition of Sepsis and Delirium. Neither of these federally funded projects conflict with the scope of the proposed DSRIP project.

**Related Category 3 Outcome Measures:**
OD-1: Primary Care and Chronic Disease Management
Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)

**Reasons/rationale for selecting the outcome measures:**
Rationale for choice of using one standalone measure is that it is most specific for the intervention. It has been well established that unnecessary readmissions can be prevented by implementing various measures to ensure outpatient follow-up.\(^{\text{xix}}\)

Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Our goal is that by year four we will have 60% with follow up within 30 days, and by year 5 we will have 80%.

Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. As it is difficult to arrange appointments so close to discharge because of patient and physician factors, our goal is that by the fourth year we will have 40% follow up within seven days and by the fifth year, 50%.

**Relationship to other Projects:** This project may share space with an OB care coordinator program run by SJMH, and may have overlapping patients.

**Relationship to other Performing Providers Projects within the RHP:**
The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Multiple other Behavioral Health Innovations include care navigators, transition coaches, or case managers. We seek to participate in lessons-learned with all of these programs. We also plan to collaborate with entities receiving Federal SAMSHA funding such as Community Mental Health services block grant, Substance Abuse Prevention and Treatment Block Grant or other mental health and substance abuse grants, (Harris County Adult Treatment STAR Drug Courts, TI021529). The transition nurse would be reaching out to connect the patient with right source of care.

**Plan for Learning Collaborative:**
We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region’s health care system.
**Project Valuation:**
Our project’s sole focus is the improvement of care hand-offs of behavioral health patients from the acute setting, be that inpatient or emergency department, to the appropriate ambulatory or home care setting. The costs associated with the ineffective current manner in which such care is provided today adds to the unnecessary costs of care that the state is paying each year. As such, we feel that this project covers the costs that our organization will incur to develop such a program plus allow for incentive to use such resources effectively and efficiently.

Our organization shares the need to improve the way that behavioral health care is delivered because we lose hundreds of thousands of dollars providing such care each year. As such, our incentives are perfectly aligned with the goals of the state’s DSRIP project intentions to not only enhance care, but better utilize state taxpayer monies at the same time.

All milestones and metrics were given equal weight and valuation for this project.
### Preventing Behavioral Health Readmissions by Implementing Care Transition Coordination
(Mental Health Program Innovation and Redesign through use of Psychiatric Care Managers)

Methodist Willowbrook Hospital

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s)</th>
<th>140713201.3.1</th>
<th>IT 1.18</th>
<th>Follow up after Hospitalization for Mental Illness</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1** [P-1]: Establish Team to support or lead project

**Metric 1**[P-1.1]: Establishment of Team Baseline/Goal: 100% complete Data Source: program documents. List of team members Milestone 1 Estimated Incentive Payment: $201,949

**Milestone 2** [P-2]: Collect information and /or analyze data on factors contributing to preventable readmissions within 30 days.

**Metric 1** [P-2.4]: Develop an electronic report on readmission data Baseline: Report developed and criteria established. Data Source: program documents. Milestone 2 Estimated Incentive Payment: $332,620

**Milestone 8** [P-15]: Educate appropriate clinical staff on key contributing factors to preventable readmissions.

**Metric 1** [P-15.1] X % of key clinical staff completing educational sessions Baseline/Goal: 50% of emergency medicine, internal medicine & behavioral health clinicians complete education.. Data Sources: Internal hospital records/documentation; Training curricula Milestone 8 Estimated Incentive Payment : $332,620

**Milestone 9** [P-17]: Re-engineer hospital discharge process for all admitted patients.

**Metric 1** [P-17.1]: Development of high-risk tool and discharge checklist Baseline/Goal: 100% complete Data Source: EMR Documentation of high risk tool and discharge check list including medication reconciliation Milestone 9 Estimated Incentive Payment: $332,620


**Metric 1** [P-23.1]: X% of post-acute partners trained Baseline/Goal: 100 % of 4 transition nurses trained Data Source: Internal Hospital Records. Milestone 12 Estimated Incentive Payment: $311,832.50

**Milestone 13** [P-28]: Gap analysis regarding patient communication with doctors, nurses, and/or discharge information.

**Metric 1** [P-28.1]: Analysis complete Baseline/Goal: 100% complete Data Source: Internal hospital records/documentation Milestone 13 Estimated Incentive Payment: $311,832.50

**Milestone 16** (P-32) Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

**Metric 1**: (P-32.1) Participate in semiannual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in learning collaborative Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 16: Estimated Incentive Payment (maximum amount): $473,986
**PREVENTING BEHAVIORAL HEALTH READMISSIONS BY IMPLEMENTING CARE TRANSITION COORDINATION**  
(Mental Health Program Innovation and Redesign through use of Psychiatric Care Managers)

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>140713201.3.1</th>
<th>IT 1.18</th>
<th>Follow up after Hospitalization for Mental Illness</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

| **Metric 3 [P-2.6]**: Determine baseline metric for all cause 30 day readmissions  
Data Source: program documents. | **Metric 10**: [P-20] Identify community-based care transition partners.  
**Metric 1**: [P-20.1] Number of care transition partners  
Baseline/Goal: Identify at least 1 external partner.  
Data Source: Documentation of formal or information partnership  
**Metric 2**: [P-20.2] Number of partner post-acute facilities  
Baseline/Goal: Identify at least 1 external partner.  
Data Source: Documentation of formal or information partnership  
**Metric 1**: [P-20.1] Number of care transition partners  
Baseline/Goal: Identify at least 1 external partner.  
Data Source: Documentation of formal or information partnership  
**Metric 2**: [P-20.2] Number of partner post-acute facilities  
Baseline/Goal: Identify at least 1 external partner.  
Data Source: Documentation of formal or information partnership  
**Metric 1**: [P-20.1] Number of care transition partners  
Baseline/Goal: Identify at least 1 external partner.  
Data Source: Documentation of formal or information partnership  
**Metric 2**: [P-20.2] Number of partner post-acute facilities  
Baseline/Goal: Identify at least 1 external partner.  
Data Source: Documentation of formal or information partnership  
**Metric 1**: [P-20.1] Number of care transition partners  
Baseline/Goal: Identify at least 1 external partner.  
Data Source: Documentation of formal or information partnership  
**Metric 2**: [P-20.2] Number of partner post-acute facilities  
Baseline/Goal: Identify at least 1 external partner.  
Data Source: Documentation of formal or information partnership  
Milestone 10 Estimated Incentive Payment: $332,620 |

**Milestone 14 Estimated Incentive Payment:**  
$311,832.50

**Metric 1 [I-43.1]**: Metric: 20% decrease in preventable all-cause admissions and readmissions to psychiatric and other inpatient facilities;  
Goal: 20% above baseline, average from years DY 2 & DY 3.  
Data Source: Claims/encounter and clinical record data; anchor hospital and other partner hospitals, local MH authority and state MH(CARE)data system records  
**Milestone 17 Estimated Incentive Payment:**  
$473,986
### Preventing Behavioral Health Readmissions

**by Implementing Care Transition Coordination**

(Mental Health Program Innovation and Redesign through use of Psychiatric Care Managers)

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>140713201.3.1</th>
<th>IT 1.18</th>
<th>Follow up after Hospitalization for Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>140713201.2.1</td>
<td>2.17.1</td>
<td>A-G</td>
<td>Methodist Willowbrook Hospital</td>
</tr>
</tbody>
</table>

**Methodist Willowbrook Hospital**

140713201

**Year 2** (10/1/2012 – 9/30/2013)

- Appropriate FTEs based on realized patient demand.

  Data Source: Documentation of position of offer letters/ Human Resources records

  Milestone 3 Estimated Incentive Payment: $201,949

**Milestone 4:** [P-5] Develop an assessment tool to identify patients who are at high risk for readmission.

**Metric 1** [P-23.1]: X% of post-acute partners trained

Baseline/Goal: 50% of 4 transition nurses trained

Data Source: Internal Hospital Records.

Milestone 4 Estimated Incentive Payment: $332,620

**Metric 1** [P-23.1]: X% of post-acute partners trained

Baseline/Goal: 50% of 4 transition nurses trained

Data Source: Internal Hospital Records.

Milestone 11 Estimated Incentive Payment: $332,620

**Milestone 5:** [P-6] Identify evidence-based frameworks that support seamless care transitions and impact preventable 30-day readmissions.

**Year 3** (10/1/2013 – 9/30/2014)

- Metric 1 [P-23.1]: X% of post-acute partners trained

Baseline/Goal: 50% of 4 transition nurses trained

Data Source: Internal Hospital Records.

- **Milestone 15** [I-43]: Preventable All-Cause Admissions and Readmissions

  **Metric 1** [I-43.1]: Metric: 10% decrease in preventable all-cause admissions and readmissions to psychiatric and other inpatient facilities;

  Goal: 10% above baseline, average from years DY 2 & DY 3.

  Data Source: Claims/encounter and clinical record data; anchor hospital and other partner hospitals, local MH authority and state MH(CARE) data system records

  Milestone 15 Estimated Incentive Payment: $311,832.50

  (Improvement milestone, partners/training)

**Year 4** (10/1/2014 – 9/30/2015)

**Year 5** (10/1/2015 – 9/30/2016)

**Region 3**

**Regional Healthcare Partnership Plan**
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>140713201.2.1</td>
<td>2.17.1</td>
<td>A-G</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PREVENTING BEHAVIORAL HEALTH READMISSIONS</strong>&lt;br&gt;<strong>(Mental Health Program Innovation and Redesign through use of Psychiatric Care Managers)</strong></td>
<td>Methodist Willowbrook Hospital</td>
<td>140713201</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3</td>
<td>Outcome Measure(s):</td>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
</tr>
<tr>
<td>Related Category 3</td>
<td>Outcome Measure(s):</td>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
</tr>
</tbody>
</table>

Metric 1: [P-6.1] Selection of an evidence based framework.<br>Baseline/Goal: 100% developed<br>Data source: Meeting minutes selecting an evidence based framework.

Milestone 5 Estimated Incentive Payment: $201,949

**Milestone 6 [P-7]:** Develop operations manual for care transitions intervention with administrative protocols and clinical guidelines

Metric 1 [P-7.1]: Develop a written operations manual.<br>Baseline/Goal: 100% complete<br>Data Source: Written operations manual

Milestone 6 Estimated Incentive Payment: $201,949

**Milestone 7 [P-10]:** Develop plan for hospital care transition process

Metric 1: [P-10.1] Care management
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>140713201.3.1</th>
<th>IT 1.18</th>
<th>Follow up after Hospitalization for Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
</tbody>
</table>

- **tool**
  - Baseline / Goal: 100% complete
  - Data Source: Written process & protocol

- **Metric 2: [P-10.2] Transition Process Improvement Plan**
  - Baseline / Goal: 100% complete
  - Data Source: Written process & protocol

- **Milestone 7 Estimated Incentive Payment:** $201,949

| Year 2 Estimated Milestone Bundle Amount: $1,413,640 | Year 3 Estimated Milestone Bundle Amount: $1,330,480 | Year 4 Estimated Milestone Bundle Amount: $1,247,330 | Year 5 Estimated Milestone Bundle Amount: $947,972 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5):** $4,939,422
i Extrapolated from US prevalence rate in Methodist Hospital Community Needs Assessment 2011

ii Local Plan Review, History and Organizational Review FY 2006-7


vi Rush AJ. The 16-item Quick Inventory of Depressive Symptomatology (QIDS), Clinician Rating (QIDS-C), and Self-Report (QIDS-SR): a psychometric evaluation in patients with chronic major depression. Biological Psychiatry, 54 (2003), pp. 573–583


viii J. Schaefer, C. Davis Case management and the chronic care model: a multidisciplinary role Lippincotts Case Manag, 9 (2) (2004), pp. 96–103


OakBend Medical Center
Pass 1
**Project Option:** 2.4.1 Redesign to Improve Patient Experience - Implement Consumer Assessment System

**Performing Provider:** OakBend Medical Center (OBMC) / 127303903

**Unique Project ID:** 127303903.2.1

- **Provider:** OakBend Medical Center is a stand-alone hospital authority that was established in October 1947 under the original name of Polly Ryon Memorial Hospital. OakBend Medical Center has grown to a hospital system, still governed by a hospital authority. It has expanded to two hospital locations, two diagnostic imaging centers, an outpatient surgical center, a free-standing Emergency Room and a Medical Group with 7 clinic locations. The Medical Group consists of Family Practice, OB/Gyn, Infectious Disease, Podiatry, Orthopedic, Cardiology and Interventional Cardiology. OakBend was able to provide more than $29,412,325 in charity care through September during FY 2012.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix – YTD 9/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions- 5,453</td>
<td>Self-Pay- 13.8%</td>
</tr>
<tr>
<td>Births (babies delivered)- 1,080</td>
<td>Medicaid and CHIP- 19.5%</td>
</tr>
<tr>
<td>Emergency visits- 23,433</td>
<td>Medicare- 40.1%</td>
</tr>
<tr>
<td></td>
<td>Other Funding- N/A</td>
</tr>
<tr>
<td></td>
<td>Commercial Insurance- 26.6%</td>
</tr>
<tr>
<td></td>
<td>Hispanic- 39.6%</td>
</tr>
<tr>
<td></td>
<td>African American- 16.7</td>
</tr>
<tr>
<td></td>
<td>Caucasian- 34.6</td>
</tr>
<tr>
<td></td>
<td>Asian- 2.0</td>
</tr>
<tr>
<td></td>
<td>Other- 6.7</td>
</tr>
<tr>
<td></td>
<td>American Indian- 0.4</td>
</tr>
</tbody>
</table>

- **Intervention(s):** OBMC plans to establish a patient experience program where patients feel safe, have their voices heard and are empowered. This concept would involve staff education on communication skills and will be in line with the other initiatives that are designed to create an environment that promotes excellence, operational efficiency and quality patient-centered care

- **Need for the project:** This project addresses the RHP’s goal to “[d]evelop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.”

- **Target population:** All patients that seek their medical care through any of the OakBend Medical Center system entities, who will benefit from this and other projects. We plan to target all inpatients.

- **Category 1 or 2 expected patient benefits:** The goal of this project is to change the organizational culture to improve the patient experience, where patients feel safe, have their voices heard and are empowered.

  Over the course of the project, OakBend expects approximately **137,208** patient visits as a result of this project as follows:

  **45,736** patient visits in DY 3
91,472 patient visits in DY 4

137,208 patient visits in DY 5

OakBend expects approximately 33.3% of these patients will be Medicaid or indigent.

- **Category 3 outcomes**: IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS)

**Title**: Redesign to Improve Patient Experience - Implement Consumer Assessment System

**Unique RHP Project Identification Number**: 127303903.2.1

**Performing Provider Name/TPI**: OakBend Medical Center (OBMC) / 127303903

**Project Description: 2.4 / 2.4.1**

OBMC plans to establish a patient experience program where patients feel safe, have their voices heard and are empowered. This concept will involve staff education on communication skills and will be in line with the other initiatives that are designed to create an environment that promotes excellence, operational efficiency and quality patient-centered care. The program will be established to encompass any patient experience in all OBMC facilities.

Patient experience with care will be assessed through focused surveys. The architecture for patient-focused surveys should be modeled after the Consumer Assessment of Healthcare Providers and Systems (CAHPS) tool, which includes the following domains: patients are getting timely care, appointments, and information; how well providers communicate with patients; patients’ rating of provider; and assessment office staff.

OBMC will establish a Hospital Consumer Assessment of Healthcare Provider and Systems (HCAHPS) Steering committee, which will be comprised of organizational leaders, employees, and patients via their feedback. OBMC will then develop or improve upon a curriculum that will focus on staff education, communication skills and cultural diversity, as well as develop a formal policy and procedure that incorporates the communication model to include training staff on program goals and objectives. This will include competency training for all healthcare providers. We will incorporate the communication training model into the annual employee competencies. The training module will include coaching, shadowing and a feedback process. This process is designed to ensure that the knowledge acquired will be retained and performed on an ongoing basis.

**Goal(s) and relationship to Regional goal(s):**

Project goals:

The goal of this project is to change the organizational culture to improve the patient experience.

This project meets the following Region 3 goals:

This project addresses the RHP’s goal to “[d]evelop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.”
Challenges and how addressed:
Challenges include: population diversity, language barriers, implementation and ongoing monitoring, training for healthcare providers, overcoming past negative experiences; tools to identify service issues during stay; to improve performance on at least one of the three composite measures on the HCAHPS. OBMC will address these challenges by taking the steps outlined in this project narrative; in particular, OBMC will ensure that the program created under this project will effectively serve the diverse populations receiving care at OBMC. One step is to hire more bilingual staff to assist with the language barriers.

5-year expected outcome for provider and patients:
Improved patient satisfaction and provider performance which is better tailored to the needs of patients as expressed through the assessment system. We plan to do this by improving communication with patients and their families, which will lead to increased quality. Both of these positive metrics will lead to improved HCAHPS scores.

Starting Point/Baseline:
Baseline data:
OBMC currently uses patient satisfaction surveys in a limited number of clinical units and will use this data as a baseline for future project progress.
Time period for baseline:
1/1/12 to 6/30/12

Rationale:
Reasons for selecting the project option:
The feedback gained from this project will help OBMC develop tools to identify service issues during the patient’s stay so that corrective action may be implemented at that time. It will also allow OBMC to critique and revise the training process as indicated by the results achieved. These metrics will be shared with all employees on a monthly basis, highlighting for the staff possible ways to enhance the patient experience and as evidenced by our HCAHPS scores.

Project components:
We will meet the following core components:

a) Organizational integration and prioritization of patient experience.
b) Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience.
c) Implementing processes to improve patient experience in getting through to the clinical practice.
d) Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures.
Milestones and Metrics:
The following milestones and metrics were chosen for the Implement Consumer Assessment System project based on the core components and the needs of the target population:
Process Milestones and Metrics: P-1 (P-1.1); P-3 (P-3.1); P-18 P-18.1
Improvement Milestones and Metrics: I-16 (I-16.1)

Unique community need identification number the project addresses:
   CN.9: High rates of preventable hospital readmissions
   CN-11: High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
   OBMC currently uses patient satisfaction surveys in a limited number of clinical units. However, this project will allow OBMC to expand the use of patient satisfaction surveys and, more importantly, establish an infrastructure of accountability where the results of these surveys are examined by a steering committee, supported by active feedback from physicians and other practitioners, and eventually incorporated into the hospital’s infrastructure.

Related Category 3 Outcome Measure(s):
   IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS)
Reasons/rationale for selecting the outcome measure(s): This outcome measure is explicitly related to the improvement of patient satisfaction, which is also the express purpose of this project.

Relationship to Other Projects:
How project supports, reinforces, and enables other projects:
   This project will lay a foundation for, and reinforce the clinical effectiveness of OBMC’s other DSRIP projects, including:

   127303903.2.2: Establish Patient Care Navigation Program
   127303903.1.3: Implement and Utilize Disease Management Registry

Relationship to Other Performing Providers’ Projects in the RHP:
List of other providers in the RHP that are proposing similar projects:
[Blank per Anchor’s instructions.]

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

**Approach for valuing project:**

OBMC values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing this project, OBMC took into account the extent to which the implementation of a consumer assessment system would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to implement the project.

**Rationale/justification for valuation:**

The implementation of a consumer assessment system will promote and encourage patients to access care, and foster a relationship of trust and communication between patients and providers—ultimately leading to better clinical outcomes for the community. OBMC took these potential effects into account when considering the appropriate incentive payment value for this project.
## Reopen to Improve Patient Experience – Implement Consumer Assessment System

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Description</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 1 [P-1]:</td>
<td>Appoint an executive accountable for experience performance or create a percentage of time in existing executive position for experience performance.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>P-1.1 Documentation of an executive assigned responsibility experience performance.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong></td>
<td>To establish the necessary personnel and infrastructure to successfully implement the project.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td>Organizational chart or job description (if percentage of time).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment <em>(maximum amount)</em>:</td>
<td>$673,829</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 2 [P-3]:</td>
<td>Establish a steering committee comprised of organizational leaders, employees and patients/families to implement and coordinate improvements in patient and/or employee experience. Steering committee will meet at least twice a month.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong></td>
<td>P-3.1: Documentation of committee proceedings and list of committee members.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong></td>
<td>To establish the necessary personnel and infrastructure to successfully implement the project.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td>Meeting minutes, agendas, participant lists, and/or list of steering committee members.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment:</td>
<td>$735,111</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 3 [I-16]:</td>
<td>Improve patient satisfaction/experience scores.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal:</strong></td>
<td>Metric 1 I-16.1 Percentage improvement of patient satisfaction scores for a specific tool over baseline. Goal: 1% improvement over baseline.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td>Patient satisfaction/experience surveys such as Clinician and Group Consumer Assessment of Health Care Providers and Systems (CG CAHPS) and/or Hospital Quality Initiative Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. Raw scores provided by Jackson Group (third-party vendor).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 3 Estimated Incentive Payment:</td>
<td>$368,624</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 4 [P-1]:</td>
<td>Participate in face-to-face learning (i.e., meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 5 [I-16]:</td>
<td>Improve patient satisfaction/experience scores.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal:</strong></td>
<td>Metric 1 I-16.1 Percentage improvement of patient satisfaction scores for a specific tool over baseline. Goal: 2% improvement over baseline.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td>Patient satisfaction/experience surveys such as Clinician and Group Consumer Assessment of Health Care Providers and Systems (CG CAHPS) and/or Hospital Quality Initiative Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. Raw scores provided by Jackson Group (third-party vendor).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 5 Estimated Incentive Payment:</td>
<td>$304,515</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 6 [P-1]:</td>
<td>Participate in face-to-face learning (i.e., meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>127303903.2.1</td>
<td>2.4.1</td>
<td>2.4.1a-d</td>
<td><strong>Redesign to Improve Patient Experience – Implement Consumer Assessment System</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>--------</td>
<td>---------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OAKBEND MEDICAL CENTER</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td>127303903.3.4</td>
<td><strong>IT-1.6</strong></td>
<td>Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1</strong> P-1.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</td>
<td></td>
<td>should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance. Each participating provider should publicly commit to implementing these improvements.</td>
<td><strong>Metric 1</strong> P-1.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td></td>
<td><strong>Data Source:</strong> Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td><strong>Data Source:</strong> Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
</tr>
<tr>
<td>Milestone 4 Estimated Incentive Payment: <strong>$368,624</strong></td>
<td>Milestone 6 Estimated Incentive Payment: <strong>$304,515</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount (add incentive payments amounts from each milestone): $673,829**

**Year 3 Estimated Milestone Bundle Amount: $735,111**

**Year 4 Estimated Milestone Bundle Amount: $737,248**

**Year 5 Estimated Milestone Bundle Amount: $609,031**

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYS 2-5): $2,755,219**
Project Option: 2.9.1 Establish Patient Care Navigation Program
Performing Provider: OakBend Medical Center (OBMC) / 127303903
Unique Project ID: 127303903.2.2

• Provider: OakBend Medical Center is a stand-alone hospital authority that was established in October 1947 under the original name of Polly Ryon Memorial Hospital. OakBend Medical Center has grown to a hospital system, still governed by a hospital authority. It has expanded to two hospital locations, two diagnostic imaging centers, an outpatient surgical center, a free-standing Emergency Room and a Medical Group with 7 clinic locations. The Medical Group consists of Family Practice, OB/Gyn, Infectious Disease, Podiatry, Orthopedic, Cardiology and Interventional Cardiology. OakBend was able to provide more than $29,412,325 in charity care through September during FY 2012.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix–YTD 9/12</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions - 5,453</td>
<td>Self-Pay- 13.8%</td>
<td>Hispanic- 39.6%</td>
</tr>
<tr>
<td>Births (babies delivered) - 1,080</td>
<td>Medicaid and CHIP- 19.5%</td>
<td>African American- 16.7</td>
</tr>
<tr>
<td>Emergency visits - 23,433</td>
<td>Medicare- 40.1%</td>
<td>Caucasian- 34.6</td>
</tr>
<tr>
<td></td>
<td>Other Funding- N/A</td>
<td>Asian- 2.0</td>
</tr>
<tr>
<td></td>
<td>Commercial Insurance- 26.6</td>
<td>Other- 6.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>American Indian- 0.4</td>
</tr>
</tbody>
</table>

• Intervention(s): Patient Navigators will help and support these patients to navigate through the continuum of health care services. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations.

• Need for the project: Traditionally, a hospital’s care of patients ends the instant the patient is discharged. This project will offer targeted patient populations assistance in coordinating their care. In addition to helping individual patients, this project will allow all providers across the spectrum of care to utilize their resources more efficiently, delivering care to patients in the most appropriate setting. This will result in lower costs for the delivery system and higher patient satisfaction.

• Target population: All patients that seek their medical care through any of the OakBend Medical Center system entities, who will benefit from this and other projects. We plan to target patients with Medicaid, CHIP and Self-Pay, especially those with chronic disease(s).

• Category 1 or 2 expected patient benefits: In DY3 we plan to increase the number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services as their primary means for access to healthcare.

Over the course of the project, OakBend expects approximately 137,208 patient visits as a result of this project as follows:

45,736 patient visits in DY 3
91,472 patient visits in DY 4

137,208 patient visits in DY 5

OakBend expects approximately 33% of these patients will be Medicaid or indigent.

- **Category 3 outcomes:** IT 3.2 – Our goal is to increase scheduled appointments over baseline to PCP’s and SCP’s, by 2% in DY3, by 5% in DY4 and by 8% in DY5.

**Title:** Establish Patient Care Navigation Program

**Unique RHP Project Identification Number:** 127303903.2.2

**Performing Provider Name/TPI:** OakBend Medical Center (OBMC) / 127303903

**Project Description: 2.9 / 2.9.1**

Patient Navigators will help and support these patients to navigate through the continuum of health care services. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations. OBMC will implement and coordinate post-discharge support for patients with congestive heart failure (CHF), Diabetes, and Chronic Obstructive Pulmonary Disease (COPD). Education would begin upon admission for these specific diagnoses and follow throughout the acute inpatient stay and into the post-discharge phase.

Those patients without a Primary Care Physician (PCP) would be set up with one from OakBend Medical Group (OMG) or the Fort Bend Family Health Center (FBFHC), and the initial appointment would be coordinated and scheduled in conjunction with the patient’s availability, prior to the patient being discharged home. A follow-up call by a Community Health Worker (CHW) to remind the patient of the appointment 48-72 and again 24 hours prior to the appointment will be made. During the 48-72 hour prior appointment call, confirmation that the patient has transportation to get to the appointment would be confirmed. This coordination for transportation would be scheduled at least 24 hours in advance.

If no transportation is available, the CHW will, in collaboration with United Way, Red Cross and the County Transportation Service, coordinate to ensure that the patient has transportation to the physician office appointment.

Patient Navigators will help and support patients to navigate through the continuum of health care services. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations.
Goal(s) and relationship to Regional goal(s):

Project goals:
The goal of this project is to utilize community health workers, case managers, or other types of health care professionals as Patient Navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients.

This project meets the following Region 3 goals:

This project addresses the RHP’s goal to “[d]evelop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.”

Challenges and how addressed:

Developing a well-planned-out support system which includes education for the patient/family/caregivers; promoting and incentivizing the patient population to utilize available services in lieu of the Emergency Department (ED); hiring and training of CHWs; managing non-compliant patients; space allocation for CHWs; establishing a more focused coordination between the hospital and affiliated medical group physicians, FBCHC, the CHW and other entities to achieve the shared goal of decreased avoidable readmissions; coordination of medical information from the specific HH companies with feedback to the patient’s PCP and hospital CM staff if necessary. OBMC will structure this project in order to overcome these challenges, in part through careful planning of the project, and in part through conducting ongoing quality improvement activities for the project upon its implementation.

5-year expected outcome for provider and patients:

Improved health outcomes for patients who require post-discharge care.

Starting Point/Baseline:

Baseline data:

OBMC currently does limited post-discharge support for a small subset of its patient population (Medicare patients with certain conditions).

Time period for baseline:

1/1/12 to 6/30/12

Rationale:

Reasons for selecting the project option:

Traditionally, a hospital’s care of patients ends the instant the patient is discharged. This has resulted in fragmented or overlapping care that is complicated for patients to access and navigate. This project will offer targeted patient populations assistance in coordinating their care. In addition to helping individual patients, this project will allow all providers across the spectrum of care to utilize their resources more efficiently, delivering care to patients in the most appropriate setting. This will result in lower costs for the delivery system and higher patient satisfaction.
Project components:
The core components of this project will be:

e) Identify frequent ED users and use Patient Navigators as part of a preventable ED reduction program. Train Patient Navigators in cultural competency.
f) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as Patient Navigators.
g) Connect patients to primary and preventive care.
h) Increase access to care management and/or chronic care management, including education in chronic disease self-management.
i) Conduct quality improvement for the project, using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Unique community need identification number the project addresses:
CN.8: High rates of inappropriate emergency department utilization
CN.9: High rates of preventable hospital readmissions
CN.10: High rates of preventable hospital admissions

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
OBMC currently does limited post-discharge support for a small subset of its patient population (Medicare patients with certain conditions). This program would allow OBMC to expand the level of post-discharge support by dedicating personnel and resources, offering enhanced support such as transportation, and offering the navigation services to all patients with certain targeted conditions.

Related Category 3 Outcome Measure(s):
IT-9.2 ED Appropriate Utilization (Standalone Measure)

Reasons/rationale for selecting the outcome measure(s):
If the project is successful, then it will result in improved access to care for patients with targeted conditions. By improving access to care and ensuring that patients receive the right care in the right setting, this project will reduce the inappropriate use of the Emergency Department to deliver the same care.

Relationship to Other Projects:
How project supports, reinforces, and enables other projects:
This project will lay a foundation for, and reinforce the clinical effectiveness of, OBMC’s other DSRIP projects, including:
127303903.1.1: Implement and Utilize Disease Management Registry Functionality
127303903.1.2: Increase the number of primary care providers (PCP’s)
127303903.1.3: Expand Specialty Care Capacity
Relationship to Other Performing Providers’ Projects in the RHP:
List of other providers in the RHP that are proposing similar projects:
  [Blank per Anchor’s instructions.]

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

Project Valuation:
Approach for valuing project:
  OBMC values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.
  
  In valuing this project, OBMC took into account the extent to which the implementation of a patient care navigation program would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to implement the project.

Rationale/justification for valuation:
  The implementation of a patient care navigation program will significantly improve access to both primary and specialty care for targeted patient populations, foster the more efficient use of the community’s healthcare resources, and ultimately result in the reduction of healthcare costs; therefore, OBMC took these factors into account when considering the appropriate incentive payment value for this project.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> P-1: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. <strong>Metric 1</strong> P-1.1 Provide report identifying the following:</td>
<td><strong>Milestone 2</strong> P-3: Provide care management/navigation services to targeted patients. <strong>Metric 1</strong> P-3.1 Increase in the number or percentage of targeted patients enrolled in the program. <strong>Baseline/Goal:</strong> No patient care navigation program currently in place. <strong>Data Source:</strong> Enrollment reports. <strong>Milestone 2 Estimated Incentive Payment:</strong> $395,829</td>
<td><strong>Milestone 3</strong> I-6: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services . <strong>Metric 1</strong> I-6.4 Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment <strong>Goal:</strong> 5% increase over baseline. <strong>Data Source:</strong> Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program. (Approximately 2,286 patient visits) <strong>Milestone 4 Estimated Incentive Payment:</strong> $396,979</td>
<td><strong>Milestone 4</strong> I-6: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services . <strong>Metric 1</strong> I-6.4 Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment <strong>Goal:</strong> 10% increase over baseline. <strong>Data Source:</strong> Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program. (Approximately 4,573 patient visits) <strong>Milestone 6 Estimated Incentive Payment:</strong> $327,939</td>
</tr>
<tr>
<td>- Targeted patient population characteristics (e.g. patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy).</td>
<td>- Gaps in services and service needs.</td>
<td>- How program will identify, triage and manage target population (i.e. policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts).</td>
<td>- Ideal number of patients targeted for enrollment in the patient navigation program.</td>
</tr>
<tr>
<td>- Number of Patient Navigators needed to be hired.</td>
<td>- Available site, state, county and clinical data including flow patient cases, in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, and percentage of monolingual patients.</td>
<td>- Baseline/Glal: To conduct needs</td>
<td>- Baseline/Glal: To conduct needs</td>
</tr>
</tbody>
</table>

### Milestone 6

**I-6 Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services.**

- **Metric 1** I-6.4 Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment
  - **Goal:** 10% increase over baseline.
  - **Data Source:** Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program.
  - (Approximately 4,573 patient visits)

- **Milestone 6 Estimated Incentive Payment:** $327,939

### Milestone 7

**P-1: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.**

At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance.

- **Milestone 7 Estimated Incentive Payment:** $327,939
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 Estimated Incentive Payment</strong> <em>(maximum amount): $725,662</em></td>
<td><strong>Milestone 3 Estimated Incentive Payment:</strong> $395,829</td>
<td><strong>Milestone 5 Estimated Incentive Payment:</strong> $396,979</td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $327,939</td>
</tr>
</tbody>
</table>

**Data Source:** Program documentation, EHR, claims, needs assessment survey.

Each participating provider should publicly commit to implementing these improvements.

**Metric 1 P-1.1:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Goal:** To participate in a learning collaborative and continuously improve the project effectiveness.

**Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations and/or meeting notes.

**Year 2 Estimated Milestone Bundle Amount** *(add incentive payments amounts from each milestone): $725,662* | **Year 3 Estimated Milestone Bundle Amount:** $791,658 | **Year 4 Estimated Milestone Bundle Amount:** $793,959 | **Year 5 Estimated Milestone Bundle Amount:** $655,880 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5): $2,967,159*
OakBend Medical Center
Pass 2
**Project Option:** 2.6.1 Implement Evidence-Based Health Promotion Programs – Breastfeeding

**Performing Provider:** OakBend Medical Center (OBMC)/127303903

**Unique Project ID:** 127303903.2.3

- **Provider:** OakBend Medical Center is a stand-alone hospital authority that was established in October 1947 under the original name of Polly Ryon Memorial Hospital. OakBend Medical Center has grown to a hospital system, still governed by a hospital authority. It has expanded to two hospital locations, two diagnostic imaging centers, an outpatient surgical center, a free-standing Emergency Room and a Medical Group with 7 clinic locations. The Medical Group consists of Family Practice, OB/Gyn, Infectious Disease, Podiatry, Orthopedic, Cardiology and Interventional Cardiology. OakBend was able to provide more than $29,412,325 in charity care through September during FY 2012.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix – YTD 9/12</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions- 5,453</td>
<td>Self-Pay- 13.8%</td>
<td>Hispanic- 39.6%</td>
</tr>
<tr>
<td>Births (babies delivered)- 1,080</td>
<td>Medicaid and CHIP- 19.5%</td>
<td>African American- 16.7</td>
</tr>
<tr>
<td>Emergency visits- 23,433</td>
<td>Medicare- 40.1%</td>
<td>Caucasian- 34.6</td>
</tr>
<tr>
<td></td>
<td>Other Funding- N/A</td>
<td>Asian- 2.0</td>
</tr>
<tr>
<td></td>
<td>Commercial Insurance- 26.6</td>
<td>Other- 6.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>American Indian- 0.4</td>
</tr>
</tbody>
</table>

- **Intervention(s):** OBMC will educate and train patients and staff on the health benefits of breastfeeding, as well as evidence-based strategies to enhance breastfeeding. In furtherance of this goal, OBMC will partner with Fort Bend Family Health Center (FBFHC) to educate their staff and the community on the importance of initiating early breastfeeding. The training will incorporate the development of educational materials in both Spanish and English.

- **Need for the project:** One of the Region’s goals is to “[t]ransform health care delivery from a disease-focused to a wellness model. Breastfeeding has been shown to have a positive impact on infant health. By implementing an evidence-based program aimed at promoting breastfeeding, OBMC can make an effort to increase the incidence of breastfeeding in the community.

- **Target population:** This project is explicitly tied to postnatal care and we plan to target patients with Medicaid, CHIP and Self-Pay.

- **Category 1 or 2 expected patient benefits:** The implementation of an evidence-based breastfeeding promotion program will directly contribute to the health outcomes of the community and has been linked to a reduction in chronic diseases later in life.

  Over the course of the project, OakBend expects approximately **1,943** patient visits as a result of this project as follows:

  **1606** patient visits in DY 3
1766 patient visits in DY 4

1943 patient visits in DY 5

OakBend expects approximately 33.3% of these patients will be Medicaid or indigent.

- **Category 3 outcomes**: IT-8.1 In DY3 we plan to increase improvement over baseline by 2%, in DY4 by 4% and in DY5 by 6%. OakBend will also monitor the level of low birth weight <2,500 grams at birth and will strive to maintain no more than 8% percentage of birth at this level.

**Project Option 2.6.1: Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population** - Implement Evidence-Based Health Promotion Programs – Breastfeeding Promotion Program

**Unique RHP Project Identification Number**: 127303903.2.3 / Pass 2
**Performing Provider Name/TPI**: OakBend Medical Center (OBMC) / 127303903

**Project Description**: OBMC will educate and train patients and staff on the health benefits of breastfeeding, as well as evidence-based strategies to enhance breastfeeding. In furtherance of this goal, OBMC will partner with Fort Bend Family Health Center (FBFHC) to educate their staff and the community on the importance of initiating early breastfeeding. This program will utilize a structured approach that incorporates training, motivation and specific practices for implementation.

This program will involve training staff on the evidence-based strategies to promote exclusive breastfeeding during the initial hospitalization of the mother. Because evidence has shown that the health benefits of breastfeeding, and the mechanisms by which human milk confers protection against disease is essential. The training will incorporate the development of educational materials in both Spanish and English to be used at the educational sessions. The educational sessions will begin in the prenatal phase and continue through postpartum. The infant will be placed skin to skin and breast feeding initiated within the first 30 minutes of life. This will improve both clinical outcomes as well as quality of life.

During the educational process, staff and parents will be instructed on procedures and techniques, including hands-on modules that demonstrate correct positioning, skin to skin techniques, and proper latch, as well as the nutritional benefits of breastfeeding for baby and mother.

**Goal(s) and relationship to Regional goal(s):**

**Project goals:**

The goal of this project is to implement evidence-based strategies to promote infant wellness by developing an exclusive breastfeeding program at OBMC that will be initiated immediately following the birth of the newborn. An estimated 8.3% of babies are born with a low birth weight and nearly 40% of pregnant mothers receive no prenatal care in the first trimester. Early education of this population will improve the overall health of the
community. There are, of course, financial benefits including, no need for bottles, bottle supplies and formula, which, can cost between $800 and $1200 per year. Breastfeeding also slows the fertility process, helping to space out children and create less strain on the family’s budget.

This project meets the following Region 3 goals:

One of the Region’s goals is to “[t]ransform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system[.]” This project puts emphasis on establishing wellness and patient-centered interaction, rather than only reacting to and focusing on disease. This is a proactive approach to patient care.

Challenges:

The top challenge in developing this initiative is the language diversity of the population served at OBMC, as well as the cultural diversity and the level of education of the patients. An additional challenge will be recruiting and hiring an International Board Certified Lactation Consultant (IBCLC) who will coordinate the training sessions for physicians, nurses and parents. OBMC plans to hire the lactation consultant during milestone year two (2) of this project. The lactation consultant will be responsible for coordinating the educational sessions, performing competency assessment on staff, providing hands on and ongoing evidence based education as well as compiling and maintaining statistical data and implementing quality improvement strategies to achieve the desired outcomes.

5-year expected outcome for provider and patients:

All mothers who deliver at OBMC will be educated on the benefits of breastfeeding and the nutritional value human milk provides for their infants. OBMC will be a community resource for all breastfeeding mothers. The resource center will provide training sessions, educational information as well as equipment to assist mothers in achieving successful breastfeeding.

Starting Point/Baseline:

Baseline data:

OBMC does not currently have a certified lactation consultant on staff or a comprehensive program to promote breastfeeding. OBMC is in the process of searching for a certified breastfeeding consultant and will have this person in place by Milestone year two (2).

Time period for baseline:

1/1/12 to 6/30/12

Rationale:

Reasons for selecting the project option:

Breastfeeding has been shown to have a positive impact on infant health. By implementing an evidence-based program aimed at promoting breastfeeding, OBMC can make an effort to increase the incidence of breastfeeding in the community. This is a proven method of improving health outcomes and increasing patient satisfaction. This will improve both clinical outcomes as well as quality of life.
Project components:

The project will include opportunities to expand to a broader patient population, and identify key challenges associated with expansion of the project, including special considerations for safety-net populations.

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

- One of OakBend’s milestones in Year 4 is to implement a continuous quality improvement plan by establishing meetings with other RHP providers.

Unique community need identification number the project addresses:
- CN.20- Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
- CN.14- High rates of poor birth outcomes and low birth-weight babies

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

Although OBMC currently provides some information and guidance regarding breastfeeding, this would be a significant expansion of the program by increasing the amount of education available to both patients and staff. We plan to implement a dedicated breastfeeding resource department that is equipped with information in English and Spanish, as well as the availability of equipment and interactive training modules to better facilitate learning. The hiring of a full-time certified lactation consultant would also dedicate significantly more resources to this goal. Efforts will also be made to follow up with the patients to determine whether they are still breastfeeding post discharge. This Project allows OBMC to participate in a learning collaborative and inter-agency coordination effort with other entities whose focus is to improve quality of life for the mother and infant.

Related Category 3 Outcome Measure(s):

IT-8.1 Timeliness of Prenatal/Postnatal Care

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

This project is explicitly tied to postnatal care. Therefore, it is reasonable to measure other areas of prenatal/postnatal care.
Relationship to Other Projects:
How project supports, reinforces, and enables other projects:

This project will lay a foundation for, and reinforce the clinical effectiveness of, other DSRIP projects such as:

1.1 Expand Primary Care Capacity
2.4 Redesign to Improve Patient Experience
2.7 Implement Evidence-Based Disease Prevention Programs

Relationship to Other Performing Providers’ Projects in the RHP:

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

Project Valuation:

Approach for valuing project:
OBMC values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing this project, OBMC took into account the extent to which the implementation of an evidence-based breastfeeding promotion program would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to implement the project.

Rationale/justification for valuation:
The implementation of an evidence-based breastfeeding promotion program will directly contribute to the health outcomes of the community and has been linked to a reduction in chronic diseases later in life. OBMC took these potential effects into account when considering the appropriate incentive payment value for this project. OBMC has identified the space and is currently advertising for a certified lactation consultant to begin the process.
### Related Category 3 Outcome Measure(s):

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 [P-3]</strong>: Implement, document and test an evidence-based innovative project for targeted population; <strong>Metric 1</strong> [P-3.1]: Document implementation strategy and testing outcomes. Data Source: Performing Provider contract or other documentation of implementation TBD by Performing Provider. Milestone 1 Estimated Incentive Payment: $260,969.50</td>
<td><strong>Milestone 2 [P-2]</strong>: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community. <strong>Metric 1</strong> [P-2.1]: Document innovative strategy and plan. Data Source: Performing Provider evidence of innovative plan. Milestone 2 Estimated Incentive Payment: $260,969.50</td>
<td><strong>Milestone 5 [I-8]</strong>: Increase access to health promotion programs and activities using innovative project option. <strong>Metric 1</strong> [I-8.1]: Increase percentage of target population reached. Baseline/Goal: Documentation of target population reached, as designated in the project plan. Milestone 5 Estimated Incentive Payment: $290,974 (Approximately 58 patients are estimated to be served)</td>
<td><strong>Milestone 7 [P-7]</strong>: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. <strong>Metric 1</strong> [P-7.1]: Number of new ideas, practices, tools, or solutions tested. Data Source: Brief description of the idea, practice, tool, or solution tested each week, to be summarized at quarterly intervals. Milestone 7 Estimated Incentive Payment: $242,993.50</td>
</tr>
<tr>
<td><strong>Milestone 3</strong> [I-8]: Increase access to health promotion programs and activities using innovative project option. <strong>Metric 1</strong> [I-8.1]: Increase percentage of target population reached. Baseline/Goal: Documentation of target population reached, as designated in the project plan. Milestone 3 Estimated Incentive Payment: $290,974</td>
<td><strong>Milestone 4</strong> [P-7]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. <strong>Metric 1</strong> [P-7.1]: Number of new ideas, practices, tools, or solutions tested. Data Source: Brief description of the idea, practice, tool, or solution tested each week, to be summarized at quarterly intervals. Milestone 4 Estimated Incentive Payment: $290,974</td>
<td><strong>Milestone 5</strong> [I-8]: Increase access to health promotion programs and activities using innovative project option. <strong>Metric 1</strong> [I-8.1]: Increase percentage of target population reached. Baseline/Goal: Increase percentage of target population reached by 10% Data Source: Documentation of target population reached, as designated in the project plan. (Approximately 97 patients are estimated to be served)</td>
<td><strong>Milestone 8</strong> [P-7]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. <strong>Metric 1</strong> [P-7.1]: Number of new ideas, practices, tools, or solutions tested. Data Source: Brief description of the idea, practice, tool, or solution tested each week, to be summarized at quarterly intervals.</td>
</tr>
</tbody>
</table>

### Measures

- **3.IT-8.1** Timeliness of Prenatal/Postnatal Care
- **3.IT-8.2** Percentage of Low Birth Weight Births (CHIPRA/NQF #1382)
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.IT-8.1</td>
<td>3.IT-8.2</td>
<td>Conference calls, presentations, email, milestone 6 estimated incentive payment: $295,195</td>
<td>Milestone 8 estimated incentive payment: $242,993.50</td>
</tr>
<tr>
<td>Timeliness of Prenatal/Postnatal Care Percentage of Low Birth-Weight Births (CHIPRA/NQF # 1382)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 estimated milestone bundle amount: $521,939</td>
<td>Year 3 estimated milestone bundle amount: $581,948</td>
<td>Year 4 estimated milestone bundle amount: $590,390</td>
<td>Year 5 estimated milestone bundle amount: $485,987</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over DYs 2-5): $2,180,264
Oakbend Medical Center
Pass 3
Project Option: 2.14.3 Other Patient-Centered Wellness Management Program
Performing Provider: OakBend Medical Center (OBMC)/127303903
Unique Project ID: 127303903.2.4

- Provider: OakBend Medical Center is a stand-alone hospital authority that was established in October 1947 under the original name of Polly Ryon Memorial Hospital. OakBend Medical Center has grown to a hospital system, still governed by a hospital authority. It has expanded to two hospital locations, two diagnostic imaging centers, an outpatient surgical center, a free-standing Emergency Room and a Medical Group with 7 clinic locations. The Medical Group consists of Family Practice, OB/Gyn, Infectious Disease, Podiatry, Orthopedic, Cardiology and Interventional Cardiology. OakBend was able to provide more than $29,412,325 in charity care through September during FY 2012.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix–YTD 9/12</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions- 5,453</td>
<td>Self-Pay- 13.8%</td>
<td>Hispanic- 39.6%</td>
</tr>
<tr>
<td>Births (babies delivered)- 1,080</td>
<td>Medicaid and CHIP- 19.5%</td>
<td>African American- 16.7</td>
</tr>
<tr>
<td>Emergency visits- 23,433</td>
<td>Medicare- 40.1%</td>
<td>Caucasian- 34.6</td>
</tr>
<tr>
<td></td>
<td>Other Funding- N/A</td>
<td>Asian- 2.0</td>
</tr>
<tr>
<td></td>
<td>Commercial Insurance- 26.6</td>
<td>Other- 6.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>American Indian- 0.4</td>
</tr>
</tbody>
</table>

- Intervention(s): OBMC will formalize partnerships with local community agencies to work on projects specifically dedicated to health and wellness promotion such as Fort Bend Family Health Center (FBFHC), United Way, Weight Watchers, OBMC (OakBend Medical Group) and other agencies. We will form a task force of community members from each of the different agencies to do a needs assessment to determine targeted areas where a wellness management program in English and Spanish would be beneficial.

- Need for the project: This project directly relates to the Regional goal to “[t]ransform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services including hospital admissions, and builds on the accomplishments of our existing health care system[.]”

- Target population: All patients that seek their medical care through any of the OakBend Medical Center system entities, who will benefit from this and other projects. We plan to target patients with Medicaid, CHIP and Self-Pay, especially those with chronic disease(s).

- Category 1 or 2 expected patient benefits: OBMC does not currently operate a wellness program. However, OBMC has identified a minimum of five patient populations that would benefit from this wellness program. Most of these patients overlap to more than one population, which only increases the likelihood of non-compliance and poor quality of life.

Over the course of the project, OakBend expects approximately 162,576 patient visits as a result of this project as follows:
54,192 patient visits in DY 3
108,384 patient visits in DY 4
162,576 patient visits in DY 5

OakBend expects approximately 33.3% of these patients will be Medicaid or indigent.

- Category 3 outcomes: IT-3.4 In DY3 we plan to train staff and decrease inappropriate use of emergency department care by 2% over baseline, in DY4 by 5% and in DY5 by 8%.

**Project Option 2.14.3: “Other” project option:** Implement other evidence-based project to implement person-centered wellness self-management strategies and self-directed financing models that empower consumers to take charge of their own health care—Patient-Centered Wellness Management Program

**Unique RHP Project Identification Number:** 127303903.2.4 / Pass 2

**Performing Provider Name/TPI:** OakBend Medical Center (OBMC) / 127303903

**Project Description:**

OBMC will formalize partnerships with local community agencies to work on projects specifically dedicated to health and wellness promotion such as Fort Bend Family Health Center (FBFHC), United Way, OakBend Medical Group (OBMG), Weight Watchers and other agencies. We will form a task force of community members from each of the different agencies to do a needs assessment to determine targeted areas where a wellness management program would be beneficial.

This project will involve hiring and training of wellness staff, care coordination, development of educational materials, outreach to community of services offered in bilingual availability, access to or expanded transportation services as well as coordination for transportation, reminder calls to recipients regarding appointment times, eventually a help line for access of services offered, and printed educational materials in multiple languages. Depending on the needs assessment, outreach nurses, physical therapists or physical therapy assistants, dieticians and chaplaincy services, along with transportation coordination with Fort Bend County and other agencies providing such services, would be required. The project will also involve meetings led by nephrologists, cardiologys, pulmonologists and dieticians, etc to conduct awareness and education seminars for patients with end-stage renal diseases, congestive heart failure, COPD, diabetes and obesity.

**Goal(s) and relationship to Regional goal(s):**

Project goals:

The goal of this project is to create a wellness, self-management program that employs research-supported interventions, singly or in combination, to help individuals manage their chronic physical and behavioral health conditions.
This project meets the following Region 3 goals:

This project directly relates to the Regional goal to “[t]ransform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services including hospital admissions, and builds on the accomplishments of our existing health care system[.]”

Challenges:
Part of the difficulty in implementing this project is the ability to formalize partnerships with multiple entities. Each of the partners has particular policies and practices which may need to be altered to accommodate the new partnerships. For example, some of the intended partners may have confidentiality policies that will need to be updated to allow for the flow of information in this project. OakBend intends to address this challenge by continuing to have an open line of communication with all partners that will encourage preemptive solutions to these issues.

5-year expected outcome for provider and patients:
Improved management and compliance with treatment regimens of chronic conditions for patients, particularly patients with renal disease, COPD, congestive heart failure, diabetes and obesity.

Starting Point/Baseline:
Baseline data:
OBMC does not currently operate a wellness program. However, OBMC has identified a minimum of five patient populations, listed above, that would benefit from this wellness program. Most of these patients overlap to more than one population, which only increases the likelihood of non-compliance and poor quality of life.

Time period for baseline:
1/1/12 to 6/30/12

Rationale:
Reasons for selecting the project option:
This project will help OBMC to successfully engage the individual consumer in disease self-management and wellness activities related to chronic physical and behavioral health conditions, and empower person-centered recovery and improved health outcomes. This will improve both clinical outcomes as well as quality of life. Giving the individual consumer control over health resources is another complementary promising practice. Evidence has shown that navigation and support from community health workers and case managers trained in Motivational Interviewing resulted in increased access to and use of appropriate health services, including: more use of preventative care; more outpatient visits; more mental health and dental visits; greater adherence and persistence in taking prescribed medications for chronic conditions such as hypertension, respiratory conditions, diabetes, and high cholesterol; more medical stability for chronic conditions; and greater satisfaction with healthcare.
**Project components:**

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

- One of OakBend’s milestones in Year 4 is to implement a continuous quality improvement plan by establishing meetings with other RHP providers.

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

- CN.20- Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
- CN.23- Lack of patient navigation, patient and family education and information programs

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

This project will allow OBMC to deliver care in a much more coordinated and collaborative manner than it currently does. It will allow OBMC to participate in a learning collaborative and inter-agency coordination effort with other entities whose focus is to improve both access to and understanding of healthcare. This type of disease specific, patient-centered comprehensive wellness program would be a totally new initiative for OBMC.

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

IT-3.4 Renal Disease 30-Day Readmission Rate

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

OBMC has a relatively large population with all of the above listed chronic disease conditions. Part of the wellness program will be specifically targeted to these patient populations. Therefore, measuring the readmission rate for these chronic diseases will be a reasonable measure of this project’s success because better disease management should result in fewer readmissions for manageable diseases. Currently over 45% of our patient population either has Medicaid or are Indigent. We foresee a significant improvement in access to healthcare in this payer population. That percentage equates to approximately 3,215 inpatient admissions in 2011.

**Relationship to Other Projects:**

How project supports, reinforces, and enables other projects:

This project will lay a foundation for, and reinforce the clinical effectiveness of, other DSRIP projects such as:

1.10 Enhance Performance Improvement and Reporting Capacity
2.2 Expand Disease Specific Chronic Care Management Models
2.4 Redesign to Improve Patient Experience
2.5 Redesign for Cost Containment

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

**Plan for Learning Collaborative:**

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

**Project Valuation:**

**Approach for valuing project:**

OBMC values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project. We recently hired a Community Health Coordinator to begin the process of compiling the patient information related to the aforementioned patient populations. She be working in partnership with the other community agencies and entities to ensure a successful collaborative effort.

In valuing this project, OBMC took into account the extent to which the implementation of a patient-centered wellness program would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to implement the project.

**Rationale/justification for valuation:**

The implementation of a patient-centered wellness program will promote and encourage patients to access care, and will allow them to more closely follow their treatment plans, which will lead to better clinical outcomes and higher patient satisfaction in the community. OBMC took these potential effects into account when considering the appropriate incentive payment value for this project.
**127303903.3.7**  
**IT-3.4**  
**Renal Disease 30-Day Readmission Rate**

| Year 2  
(10/1/2012 – 9/30/2013) | Year 3  
(10/1/2013 – 9/30/2014) | Year 4  
(10/1/2014 – 9/30/2015) | Year 5  
(10/1/2015 – 9/30/2016) |
|---|---|---|---|
| **Milestone 1 [P-1]:** Develop screening criteria and a process for selecting eligible participants.  
**Metric 1 [P-1.1]:** Screening criteria and process are documented.  
Baseline/Goal: Screening criteria have not yet been developed  
Data Source: Project documentation.  
Milestone 1 Estimated Incentive Payment: $762,968.50 | **Milestone 2 [P-2]:** Identify population for intervention.  
**Metric 1 [P-2.1]:** Number of individuals meeting program entry criteria.  
Baseline/Goal: Zero patients have been identified  
Data Source: Project records  
Milestone 2 Estimated Incentive Payment: $762,968.50 | **Milestone 3 [P-4]:** Train staff in required knowledge, skills and abilities.  
**Metric 1 [P-4.1]:** Number of staff trained.  
Baseline/Goal: Screening criteria will be developed with input from the other RHP entities that we will be collaborating with on this project.  
Data Source: Project training records; training curricula.  
Milestone 3 Estimated Incentive Payment: $860,493.00 | **Milestone 5 [I-13]:** Emergency Department use.  
**Metric 1 [I-13.1]:** 5% reduction in inappropriate use of Emergency Department Care by individuals in the person-centered self-management project.  
Baseline/Goal: 5% reduction  
Data Source: Project data; claims and encounter data; medical records.  
Milestone 5 Estimated Incentive Payment: $440,778.5 |
| **Milestone 4 [I-13]:** Emergency Department use.  
**Metric 1 [I-13.1]:** 2% reduction in inappropriate use of Emergency Department (ED) Care by individuals in the person-centered self-management project.  
Baseline: We will compile data from DY 2 for utilization review and evaluation, and increase contact with these patients by the Community Health Coordinator (CHC or CHW) or worker to collaborate on steps to reduce inappropriate ED use as well as educate the patients and their families regarding other options for | **Milestone 6 [P-12]:** Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions.  
**Metric 1 [P-12.1]:** Number of new ideas, practices, tools, or solutions tested.  
Data Source: Brief description of the idea, practice, tool, or solution tested each week, and summarized at quarterly intervals.  
Milestone 6 Estimated Incentive Payment: $440,778.5 | **Milestone 7 [I-13]:** Emergency Department use.  
**Metric 1 [I-13.1]:** 8% reduction in inappropriate use of Emergency Department Care by individuals in the person-centered self-management project.  
Baseline/Goal: 8% reduction  
Data Source: 8% reduction  
Milestone 7 Estimated Incentive Payment: $483,313 | **Milestone 9 [I-13]:** Participants who are Self-Managing.  
**Metric 1 [I-13.1]:** 5% reduction in inappropriate use of Emergency Department Care by individuals in the person-centered self-management project.  
Baseline/Goal: 5% reduction  
Data Source: Project data; claims and encounter data; medical records.  
Milestone 9 Estimated Incentive Payment: $483,313 |
| **Milestone 8 [I-13]:** Participants who are Self-Managing.  
**Metric 1 [I-13.1]:** 8% reduction in inappropriate use of Emergency Department Care by individuals in the person-centered self-management project.  
Baseline/Goal: 8% reduction  
Data Source: 8% reduction  | **Milestone 10 [P-12, p. 428]:** Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions.  
**Metric 1 [P-12.1]:** Number of new ideas, practices, tools, or solutions tested.  
Data Source: Brief description of the idea, practice, tool, or solution tested each week, and summarized at quarterly intervals.  
Milestone 10 Estimated Incentive Payment: $483,313 | **Milestone 11 [I-11]:** Participants who are Self-Managing.  
**Metric 1 [I-11.1]:** 5% reduction in inappropriate use of Emergency Department Care by individuals in the person-centered self-management project.  
Baseline/Goal: 5% reduction  
Data Source: Project data; claims and encounter data; medical records.  
Milestone 11 Estimated Incentive Payment: $483,313 | **Milestone 12 [I-11]:** Participants who are Self-Managing.  
**Metric 1 [I-11.1]:** 8% reduction in inappropriate use of Emergency Department Care by individuals in the person-centered self-management project.  
Baseline/Goal: 8% reduction  
Data Source: 8% reduction  |
<table>
<thead>
<tr>
<th>127303903.2.4</th>
<th>2.14.3</th>
<th>OTHER PATIENT-CENTERED WELLNESS MANAGEMENT PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>OAKBEND MEDICAL CENTER</td>
<td>127303903</td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td>127303903.3.7</td>
<td>IT-3.4</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Renal Disease 30-Day Readmission Rate</td>
<td>Renal Disease 30-Day Readmission Rate</td>
<td>Renal Disease 30-Day Readmission Rate</td>
</tr>
<tr>
<td>non-emergent health care needs. Goal: 2% reduction</td>
<td>Data Source: Project data; claims and encounter data; medical records.</td>
<td>Milestone 4 Estimated Incentive Payment: $860,493.00</td>
</tr>
<tr>
<td>CQI: P-1 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects</td>
<td>Metric 1 [I-11.1]: Percentage of participants successfully managing their health.</td>
<td></td>
</tr>
<tr>
<td>CQI: P-1.1 Number meetings, conference calls or webinars organized by the RHP that the provider participated in.</td>
<td>Numerator: Number of participants achieving self-defined individual wellness goals.</td>
<td></td>
</tr>
<tr>
<td>Data Source: Meeting Agendas, sign-n sheets, conference calls, presentations, email</td>
<td>Denominator: Number of people participating in the person centered self-management project.</td>
<td></td>
</tr>
<tr>
<td>Meeting Agendas, sign-n sheets, conference calls, presentations, email</td>
<td>Baseline/Goal: 1,083.8 patients who are self-managing care.</td>
<td></td>
</tr>
<tr>
<td>Milestone 7 Estimated Incentive Payment: $440,778.5</td>
<td>Data Source: Project data; individual wellness plans; claims and encounter data; medical records.</td>
<td></td>
</tr>
<tr>
<td>Milestone 8 [I-11]: Participants who are Self-Managing.</td>
<td>Milestone 11 Estimated Incentive Payment: $483,313</td>
<td></td>
</tr>
<tr>
<td>Metric 1 [I-11.1]: Percentage of participants successfully managing their health.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numerator: Number of participants achieving self-defined individual wellness goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: Number of people participating in the person centered self-management project.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline/Goal: 677.4 patients who are self-managing care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>127303903.3.7</td>
<td>IT-3.4</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------</td>
<td>-------</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Self-managing care.
- **Data Source**: Project data; individual wellness plans; claims and encounter data; medical records.
- Milestone 8 Estimated Incentive Payment: $440,778.5

<table>
<thead>
<tr>
<th>Year 2 Estimated Milestone Bundle Amount:</th>
<th>Year 3 Estimated Milestone Bundle Amount:</th>
<th>Year 4 Estimated Milestone Bundle Amount:</th>
<th>Year 5 Estimated Milestone Bundle Amount:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,525,937</td>
<td>$1,720,986</td>
<td>$1,763,114</td>
<td>$1,449,939</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5)*: $6,459,976
Rice Medical Center
Pass 1
Project Option 2.7.1- Implement innovative evidence-based strategy to increase appropriate use of technology and testing: Expand Use of Immunization Tracking

**Unique RHP Project Identification Number:** 212060201.2.1

**Performing Provider/TPI:** Rice/212060201

- **Provider:** Rice Medical Center is a 25-bed critical access hospital with Trauma IV designation in Eagle Lake, Texas serving an 1100 square mile area and a population of approximately 20,000.

- **Intervention(s):** Rice will implement across-the-board tracking of patients’ immunization schedules and completed immunizations in order to avoid duplication and tardiness, and to promote preventative health care.

- **Need for the project:** Rice Medical Center currently reports only on pediatric immunizations. The hospital needs to expand reporting through additional age groups, and can do so through its critical access hospital and rural health clinics in Southern Colorado County and Northern Wharton County. Keeping track of immunizations (including yearly flu and bacterial pneumonia shots) is an especially important endeavor to promote the health of the elderly citizens in Colorado County, who are more susceptible to disease and more likely to have difficulty tracking their immunization history. The RHP 3 Workgroups have identified that the Region as a whole suffers from a lack of immunization compliance, resulting in rising incidence of preventable illnesses such as mumps, measles, pertussis, and tuberculosis.

- **Target population:** Rice Medical Center, through its hospital and clinics, provides approximately 28,000 individual patient encounters per year, treating an estimated 7700 patients. All of these can benefit from this project if/when they receive immunizations in the future, and approximately 40% are Medicaid-eligible or uninsured. In 2012, Rice immunized approximately 1200 adult patients.

- **Category 1 or 2 expected patient benefits:** The project seeks to track immunizations for 30% of its adult patients receiving immunizations by the end of DY3 (estimated to be at least 360 patients in the registry), 50% by the end of DY4 (estimated to be at least 600 patients in the registry), and 70% by the end of DY5 (estimated to be at least 840 patients in the registry). This tracking will benefit patients who will enjoy additional protection from duplicative immunizations and assistance in maintaining an appropriate immunization schedule.

- **Category 3 outcomes:** IT-6.1 – Rice seeks to improve patients’ satisfaction with their timely access to appointments, care, and information regarding immunizations through providing the ImmTrack service. In DY3, Rice will establish its patients’ baseline of satisfaction with their timely access to care, appointments and information. Rice seeks to improve the satisfaction scores by 5% in DY4 and by 10% in DY5.
Project Option 2.7.1- Implement innovative evidence-based strategy to increase appropriate use of technology and testing: Expand Use of Immunization Tracking

**Unique RHP Project Identification Number:** 212060201.2.1  
**Performing Provider/TPI:** Rice/212060201

**Project Description:**  
Rice will implement across the board tracking of patients’ immunization schedules and immunizations received in order to avoid duplication and tardiness, and to promote preventative health care.

Rice Medical Center currently reports only on pediatric immunizations. The hospital needs to expand reporting through additional age groups, and can do so through its critical access hospital and rural health clinics in Southern Colorado County and Northern Wharton County. Keeping track of immunizations (including yearly flu and bacterial pneumonia shots) is an especially important endeavor to promote the health of the elderly citizens in Colorado County, who are more susceptible to disease and more likely to have difficulty tracking their immunization history.

**Goals and Relationship to Regional Goals:**

Rice’s specific goals for this project include:
- Expand ImmTrack registry to include adult immunizations/inoculations
- Include at least 30% of adults receiving immunizations during DY3 into the registry, at least 50% of adults receiving immunizations during DY4 into the registry, and at least 70% of adults receiving immunizations during DY5 into the registry.

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

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

**Challenges:**

Rice expects challenges in the following areas: (1) training providers to use the ImmTrack technology to track the immunization history and schedule for all patients visiting the hospital or its clinics who receive immunizations; (2) educating patients about the benefits of maintaining a punctual immunization schedule; and (3) obtaining an accurate baseline history from patients; and the ability of computer systems to dependably collect and report.

Rice will confront these challenges by organizing comprehensive training session for providers before the program is in place. Rice’s providers will communicate with clients about the benefits of this program, and the hospital may use social media forums to reach out to community members who may not visit the hospital or clinics. Rice will attempt to gather the most accurate information available, and the program will only become more successful as the years go by and the data is more accurate.

**5-year Expected Outcome for Provider and Patients:**

Rice expects to have 70% of its patients seen in the ImmTrack system, enabling Rice to avoid duplication and to inform patients when they are due for updated shots. Increased reporting will allow Rice Medical Center to provide better quality treatment to patients because physicians will have access to reliable information about the patients’ medical history, and will be able to identify patients who are overdue for immunizations.

**Starting Point/Baseline:**

Rice Medical Center currently reports only on pediatric immunizations. In 2012, Rice estimates that it provided immunizations to approximately 1200 patients through its Eagle Lake and East Bernard clinics. This number should increase when the Wallis clinic comes into practice.

**Rationale:**

Rice Medical Center currently reports only on pediatric immunizations. The expansion of this reporting will allow the hospital to manage adult patients’ immunization needs in a coordinated manner. This is important for several reasons: Colorado County has a high morbidity rate, some of which is likely attributable to flu and pneumonia infections that could be prevented by immunizations (as well as other conditions); and, Colorado County has a high rate of premature death, at least some of which is likely related to infections that can be prevented by maintaining regularly scheduled immunizations. Additionally, the RHP 3 Workgroups have identified that the Region as a whole suffers from a Lack of immunization compliance, resulting in rising incidence of preventable illnesses such as:

- Mumps
- Measles
- Pertussis
- Tuberculosis

Regional Healthcare Partnership Plan
Region 3
Project Components:
With the development of the Disease Management Registry: Expand use of immunization tracking Project we propose to meet the required project component 2.7.1 - Implement innovative evidence-based strategy to increase appropriate use of technology and testing

Milestones & Metrics:
Process milestones and metrics: P-2 (P-2.1)
Improvement milestones and metrics: I-5 (I-5.1)

Unique community needs identification numbers the project addresses:
Ties to unique community needs: CN.1, CN.6, CN.7, CN.10, CN.17, CN.19

Related Category 3 Outcome Measure(s):
OD 6, IT 6.1(1) Rice selected this outcome because expanding the use of the ImmTrack system will allow the hospital to reach out to patients with immunization reminders (e.g. beginning of flu season) and assure that they are scheduled for timely appointments and shots when due. This service to patients is intended to increase their satisfaction with Rice’s healthcare delivery, and the survey given to patients in the registry should support patients’ increased satisfaction with the program.

Relationship to other Projects:
This project relates to the following projects: Reduce Inappropriate Use of the ED and Establish the Wallis Clinic. These projects will work in tandem to improve the system’s ability to track patients and assist patients in managing their needed immunizations.

Relationship to Other Performing Providers’ Projects in the RHP:
The sheer volume of population as well as the complexity of patient conditions dictate the need of numerous disease registries in our region to properly identify and manage chronic conditions. The concept is utilized consistently throughout our region in order to help achieve milestones and outcomes specific to patient conditions. All disease registries presented have a similarity in concept but are unique in the sense of condition or patient population focus. The Region 3 initiative grid in the addendum reflects direct relations between all projects.

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

The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project’s value derives from the fact that it will reach almost all of Rice’s patients (and its clinics’ patients) and constitutes preventative care aimed at reducing acute episodes of disease-related symptoms. The project is valued lower than Rice’s other projects because it will take less time and investment to implement than some other projects, and the cost is expected to be lower. However, Rice believes this project meets patients’ needs, and has value for the Region in preventing the spread of disease and related hospital admissions, and improving patient’s ongoing quality of life.
<table>
<thead>
<tr>
<th>212060201.2.1</th>
<th>2.7.1</th>
<th>N/A</th>
<th>IMPLEMENT INNOVATIVE EVIDENCE-BASED STRATEGIES TO INCREASE APPROPRIATE USE OF TECHNOLOGY AND TESTING FOR TARGETED POPULATION - DISEASE MANAGEMENT Registry: EXPAND USE OF IMMUNIZATION Tracking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice</td>
<td>212060201</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- 212060201.3.2
- IT-6.1

**OD-6 Patient Satisfaction, IT 6.1(1) Percent Improvement over baseline of patient satisfaction scores**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>

**Milestone 1 [P-2]: Implement evidence-based innovational project for targeted population.**

**Metric 1 [P-2.1]:** Document implementation strategy and testing outcomes

- **Baseline/Goal:** No current tracking - Rice will train direct patient care providers in the clinics and hospital to use the ImmTrack software to create an immunization history and schedule for all patients.
- **Data Source:** Documentation of implementation

**Milestone 1 Estimated Incentive Payment: $20,246**

**Milestone 2 [I-5]: Identify percent of Rice’s hospital and clinic patients included in the ImmTrack registry**

**Metric 1 [I-5.1]: Number of patients added into ImmTrack**

- **Baseline/Goal:** Rice will include 30% of adult patients immunized in DY3 in the ImmTrack registry (anticipated to be at least 360 adult patients in the registry).
- **Data Source:** ImmTrack Registry

**Milestone 2 Estimated Incentive Payment 2: $22,087**

**Milestone 3 [I-5]: Identify percent of Rice’s hospital and clinic patients included in the ImmTrack registry**

**Metric 1 [I-5.1]: number of patients added into ImmTrack**

- **Baseline/Goal:** Rice will include 50% of adult patients immunized in DY4 in the ImmTrack registry (anticipated to be a total of 600 adult patients in the registry).
- **Data Source:** ImmTrack Registry

**Milestone 3 Estimated Payment Incentive Payment: $22,151**

**Milestone 4 [I-5]: Identify percent of Rice’s hospital and clinic patients included in the ImmTrack registry**

**Metric 1 [I-5.1]:**

- **Numerator:** number of patients added into ImmTrack
- **Baseline/Goal:** Rice will include 70% of adult patients immunized during DY5 in the ImmTrack registry (anticipated to be at least 840 adult patients in the registry).
- **Data Source:** ImmTrack Registry

**Milestone 4 Estimated Payment Incentive Payment: $18,299**

**Year 2 Estimated Milestone Bundle Amount:** $20,246

**Year 3 Estimated Milestone Bundle Amount:** $22,087

**Year 4 Estimated Milestone Bundle Amount:** $22,151

**Year 5 Estimated Milestone Bundle Amount:** $18,299

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $82,783
Project Option: 2.2.2 - Apply Evidence Based Care Management Model to Patients Identified as Having High Risk Health Needs: Chronic Disease Outreach

Unique RHP Project Identification Number: 212060201.2.2

Performing Provider/TPI: Rice/212060201

- **Provider**: Rice Medical Center is a 25-bed critical access hospital with Trauma IV designation in Eagle Lake, Texas serving an 1100 square mile area and a population of approximately 20,000.

- **Intervention(s)**: Rice will partner with the Colorado County Health Department and other local stakeholders to provide an organized, systematic approach to chronic disease outreach, reduction, and management using the Care Management Model. Specifically, Rice will identify patients with conditions or health statuses that place them at high risk for hospitalization, acute episodes, diminished quality of life, and long-term interventions (i.e. reduction in ADLs, inability to live independently, progression of the disease at a fast pace). Rice is already aware that diabetes is a prevalent condition within Region 3 and Colorado County, so the care management model will be implemented for those patients. Other potential targets will be patients with hypertension, heart disease, COPD, or other conditions identified as prevalent and placing patients at risk for costly and invasive health care interventions.

- **Need for the project**: Colorado County has a high rate of obesity (29%) and physical inactivity (31%), both of which are linked to chronic diseases such as diabetes and hypertension. Colorado County has a higher rate of poor physical and mental health days, as well as a significantly higher rate of premature death and mortality, than both Harris County and the statewide average (again, which are at least partially linked to chronic disease). This project seeks to bridge the gap in care for the members of the population who are included in these statistics and likely suffer from chronic conditions.

- **Target population**: The target population of this project includes the chronically ill patients Rice (and its clinics) treats each year. In 2012, Rice treated 171 unique patients with COPD (30% Medicaid/uninsured); 535 unique patients with diabetes (25% Medicaid/uninsured); and 1423 unique patients with hypertension (22% Medicaid/uninsured). Each of these groups of patients will be directly targeted by this project. The target population will also indirectly include frequent flyers in Rice’s ED, wherein approximately 71% of the patient conditions are deemed non-emergent. Finally, patients with a history of PPAs and PPRs will be targeted. Rice’s rate of PPAs linked to diabetes, COPD, and hypertension is approximately 20%, and the leading condition linked to PPRs is COPD.

- **Category 1 or 2 expected patient benefits**: Rice will identify three prevalent chronic diseases to target using the Care Management Model and implement the program for the targeted conditions by the end of DY3. By the end of DY3, Rice expects to have 20% of the diagnosed patients in the target population of the three chronic conditions identified to be enrolled in the care management program (estimated to include 425 patients). In DY4, Rice will increase the number of targeted patients participating in care management to 35% of the target patients (estimated to include 745 patients total);
and in DY5 Rice will increase the number of targeted patients participating in care management to 50% of the target population (estimated to include 1065 patients).

- **Category 3 outcomes**: IT-10.1 – Through this project, Rice seeks to improve the quality of life scores for Rice patients participating in the Care Management program by 5% in DY4 over the baseline established in DY3, and by 10% in DY5.
Project Option: 2.2.2 - Apply Evidence Based Care Management Model to Patients Identified as Having High Risk Health Needs: Chronic Disease Outreach

Unique RHP Project Identification Number: 212060201.2.2
Performing Provider/TPI: Rice/212060201

Project Description:
*Rice proposes to provide a systematic approach to chronic disease outreach, reduction, and management.*

Rice will partner with the Colorado County Health Department and other stakeholders to provide an organized, systematic approach to chronic disease outreach, reduction, and management. Patient education, follow-up, and management will result in better overall health outcomes for the targeted population, including increased quality of life, reduced use of acute care, and slower progression of chronic disease. Developing an effective outreach program that educates patients to the benefits of preventative and management practices; providing and training staff.

Specifically, Rice will identify patients with conditions or health statuses that place them at high risk for hospitalization, acute episodes, diminished quality of life, and long-term interventions (i.e. reduction in ADLs, inability to live independently, progression of the disease at a fast pace). Rice is already aware that diabetes is a prevalent issue in the State and within Region 3 and Colorado County, so the care management model will be used for those patients. Other potential targets will be patients with hypertension, heart disease, COPD, or other conditions identified as prevalent and placing patients at risk for costly and invasive health care interventions.

Goals and Relationship to Regional Goals:
The goal of this project is to develop and partner with the Colorado County Health Department and implement chronic disease management interventions that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization. Specific goals include:

- By the end of DY3, Rice expects to have 20% of the diagnosed patients in the target population of the three chronic conditions identified to be enrolled in the care management program (estimated to include 425 patients).
- In DY4, Rice will increase the number of targeted patients participating in care management to 35% of the target patients (estimated to include 745 patients total)
- In DY5 Rice will increase the number of targeted patients participating in care management to 50% of the target population (estimated to include 1065 patients).
While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following:

**Project Goals:**

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

**Challenges:**
Expected challenges include recruiting staff for the clinic, negotiating space for the clinic, reaching out to traditionally underserved communities, engaging in effective patient education, and doing so with limited resources. To address these challenges, Rice will work closely with the community to develop a plan to address these concerns and seek guidance from local resources including providers, associations, and other stakeholders to ensure we implement and provide the most effective process for positive outcomes for our community. We will create an organized, comprehensive program for reaching out to the target populations in Colorado County and coordinating their care to include medication management, lifestyle education, support, and health status monitoring.

**5 Year Expected Outcome for Provider and Patients:**
By developing an effective outreach program that educates patients about their chronic conditions and the benefits of preventative and management practices we expect to see a significant number of patients receiving care under our Chronic Care Model and by DY 5 expect to see a 50% increase (over the baseline) of the target population receiving care under this model. Through our comprehensive care coordination and ongoing management of the target population we also expect to see patients with improved symptoms and function which are two essential components of health-related quality of life.

**Starting Point/Baseline:**
Residents within the Rice Hospital District currently experience a high rate of diabetes, COPD and hypertension: 535 of Rice’s patients are diagnosed diabetic, 171 are diagnosed with COPD, and 1423 are diagnosed with hypertension. Rice will perform a gap analysis in DY 2 to
determine the most prevalent and/or underserved chronic disease for which the greatest impact can be realized in DYs 4 and 5.

**Rationale:**
Because Rice does not currently have an organized, systematic approach to chronic disease outreach, reduction, and management, at-risk patients in the community often receive little to no professional support. Colorado County has a high rate of obesity (29%) and physical inactivity (31%), both of which are linked to chronic diseases such as diabetes and hypertension. Colorado County has a higher rate of poor physical and mental health days, as well as a significantly higher rate of premature death and mortality, than both Harris County and the statewide average (again, which are at least partially linked to chronic disease). This project seeks to bridge the gap in care for the members of the population who make up these statistics and likely suffer from common chronic conditions.

**Project Components:**
This project will address the core requirement of this project option which is to apply evidence-based care management model to patients identified as having high-risk health care needs.

**Milestones and Metrics:**
The following milestones and metrics were chosen for the chronic disease outreach project based on the requirements and the needs of this target population:
Process Milestones and Metrics: P-X (P-X.1); P-3 (P-3.1)
Improvement Milestones and Metrics: I-17 (I-17.1)

**Unique community needs identification numbers:**
Ties to unique Region community needs: CN.1, CN.7, CN.9, CN.10, CN.20, CN.23, CN.24

**Related Category 3 Outcome Measure(s):**
OD-10 Quality of Life/Functional Status, IT 10.1 Quality of Life – demonstrate improvement in quality of life scores, as measured by evidence based and validated assessment tool for the target population. Rice chose this outcome measure (improvement target) because the purpose of the outreach is to assist patients with chronic disease to maintain their health and well-being by managing their condition, which ties directly into their ongoing quality of life.

**Relationship to other Projects:**
This project is related to the FP/OB project, the Diabetes Center project, and the Reducing Inappropriate Use of the ED project. These initiatives are intended to work in tandem to create better patient outcomes for local residents suffering from chronic disease who do not have adequate access to primary care.

**Relationship to Other Performing Providers’ Projects in the RHP:**
Healthcare costs are significantly increased within a patient base with such aggressive chronic conditions that have gone untreated. The initiatives focused to chronic disease management focus to conditions such as asthma, hypertension, and diabetes and are similar in the approach
of managing & proactively treating chronic conditions in order to reduce 30-day readmission rates, inappropriate emergency department utilization, and healthcare costs. The Region 3 Initiative grid allows a cross reference of initiatives associated with chronic disease management. (addendum)

**Plan for Learning Collaborative:**

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

**Project Valuation:**

The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Chronic disease management is essential to improving the short- and long-term health outcomes for Colorado County’s residents, and for reducing the cost of health care delivery in the Region. Chronic diseases such as diabetes, hypertension, COPD, and heart disease are fairly prevalent around Texas, and this will likely be the case for Rice’s catchment area. Thus, the project will touch a broad base of the surrounding population. The project will take initial investment to create the parameters and identify the target population, and afterward to maintain communication with patients to manage their conditions and medication.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome Measure(s):</td>
<td>212060201.3.3</td>
<td>Rice</td>
<td>IT 10.1</td>
<td>OD 10 Quality of Life/Functional Status</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 1</strong> [P-X]: Conduct a needs/gap analysis in order to inform the establishment or expansion of services/programs</td>
<td><strong>Metric 1</strong> [P-X.1] Assessment and findings of the inquiry. Baseline/Goal: Rice will engage in a survey of its Colorado County patient records and community outreach, along with coordinate with the Colorado County Health Department to identify the 3 chronic conditions putting patients most at risk that are currently not managed under a care model. Data source: Report of the findings Milestone 1 Estimated Incentive Payment: $40,492</td>
<td><strong>Metric 1</strong> [P-3.1] Documentation of care management program Baseline/Goal: Rice will create an organized, comprehensive program for reaching out to the target populations in Colorado County and coordinating their care to include medication management, lifestyle education, support, and health status monitoring. Data source: Program materials Milestone 2 Estimated Incentive Payment: $44,174</td>
<td><strong>Metric 1</strong> [I-17.1] Increase % of target population receiving care under the Chronic Care Model Goal: By the end of DY3 Rice expects to have 20% of the target population in the three diseases identified enrolled in the care management program (estimated to include 425 patients). In DY4, Rice will increase this percentage of targeted patients enrolled in the program to 35% (estimated to include 745 patients total). Data source: Registry Milestone 3 Estimated Incentive Payment : $44,303</td>
<td><strong>Metric 1</strong> [I-17.1] Increase % of target population receiving care under the Chronic Care Model Goal: By the end of DY4 Rice expects to have 35% of the target population in the three diseases identified enrolled in the care management program (estimated to include 745 patients). In DY5, Rice will increase this percentage of targeted patients enrolled in the program to 50% (estimated to include 1065 patients total). Milestone 4 Estimated Incentive Payment: $36,598</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $40,492</td>
<td>Year 3 Estimated Milestone Bundle Amount: $44,174</td>
<td>Year 4 Estimated Milestone Bundle Amount: $44,303</td>
<td>Year 5 Estimated Milestone Bundle Amount: $36,598</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> <em>(add milestone bundle amounts over Years 2-5)</em>: $165,567</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Project Option 2.6.2 - Establish self-management programs and wellness using evidence-based designs

Unique RHP Project identification number: 212060201.2.3
Performing Provider/TPI: Rice/212060201

• Provider: Rice Medical Center is a 25-bed critical access hospital with Trauma IV designation in Eagle Lake, Texas serving an 1100 square mile area and a population of approximately 20,000.

• Intervention(s): Rice will develop a Certified Diabetes Teaching Center to educate and assist patients with managing their chronic disease. Rice will provide guidance to at-risk community members to accomplish the goal of prevention and management of diabetes for at-risk patients. Certified Diabetes Teaching Centers promote self-management for diabetic patients to achieve individualized behavioral and treatment goals that optimize health outcomes, which will benefit individual patients and the healthcare delivery system in Region 3.

• Need for the project: Currently, the community does not have a certified diabetes teaching center. Residents within the Rice Hospital District currently must travel long distances to urban providers or rely on primary care physicians for specific education related to diabetes management and prevention. A large portion of the population is both unable to travel and does not maintain an established relationship with a primary care physician. Presently, 15% of Colorado County residents receiving primary care are not even screened for diabetes. Nearly 1/3 of adult residents are obese, and 31% of the population engages in physical inactivity, both of which are linked to the onset and exacerbation of diabetes. Finally, the County has a higher rate of preventable hospital stays than the State wide average and Harris County, some of which are related to diabetes.

• Target population: Approximately 535 of the patients Rice currently treats in its hospital and local clinics are diagnosed with Type I or II diabetes and of those patients 40-50% are Medicaid eligible or uninsured. These patients are the direct target population of this project, while patients in the community who are at risk or pre-diabetic are the secondary target of this project (which Rice predicts increases the target population by at least 2000 patients, assuming 29% of the adult population of Colorado County is obese (16000 x .29 = 4600), and that fewer than half of those are pre-diabetic or undiagnosed diabetic and could receive treatment in Eagle Lake).

• Category 1 or 2 expected patient benefits: The project seeks create an operational Certified Diabetes Teaching Center, including staff trained in protocols and community outreach, with approximately 400 targeted patients receiving interventions by the end of DY3. In DY 4, Rice intends to measure the number of patients identified with diabetes who are receiving disease-specific interventions through the diabetes center, which it expects to be 600 patients. In DY5, Rice will increase the number of targeted patients receiving disease-specific interventions through the Center by 200 additional patients over DY4 (resulting in an estimated 800 patients receiving interventions through the Diabetes Center).
• **Category 3 outcomes:** IT-1.10 – Rice seeks to increase the percentage of patients it treats in its hospital and clinics with controlled blood sugar (HbA1c of 9% or lower) by 10% over baseline in DY5.
Project Option 2.6.2 - Establish self-management programs and wellness using evidence-based designs

**Unique RHP Project identification number:** 212060201.2.3  
**Performing Provider/TPI:** Rice/212060201

**Project Description:**
*Rice will develop and implement a program for diabetic care management support in its primary care clinics.*

Rice will develop a Certified Diabetes Teaching Center to educate and assist patients with managing their chronic disease. Rice will provide guidance to at-risk community members to accomplish the goal of prevention and management of diabetes for at-risk patients. Establishing self-management and wellness programs for our targeted population we provide the best opportunity for positive results and ongoing outcomes.

**Goals and Relationship to Regional Goals:**

Rice’s specific goals for this project include:
- Identify and take the steps necessary to establish a Certified Diabetes Education Center in the community
- Provide disease-specific interventions for Rice’s diabetic and pre-diabetic patients (estimated to include at least 600 patients) in DY4, and to increase the DY4 number of patients receiving interventions by 200 of Rice’s diabetic and pre-diabetic patients (estimated 800 patients) in DY5

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

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

Challenges:
Rice expects challenges as follows: 1) developing a program eligible for certification as a certified teaching center; 2) training and/or acquiring qualified staff to administer the program; and 3) educating patients about the benefits of preventative care. Rice intends to address these challenges by researching best practices and planning effectively to implement a center that will receive certification. As part of developing the plan, Rice will create a timeline and allocate resources for timely training and/or recruiting of staff, so as to coincide with the implementation of the center. Finally, Rice will engage stakeholders in reaching out to the at-risk community by using innovative methods, such as social media, provider outreach, or other community messaging forums. Many of the patients with diabetes and/or who are pre-diabetic are in their precarious health situation due to unwillingness or inability to manage their conditions. This lack of disease management will likely extend for some targeted patients to their willingness to participate in the Diabetes Center.

5-Year Expected Outcome for Provider and Patients:
Rice expects a high rate of prevention of the onset of Type II diabetes for targeted pre-diabetics in the community through provider-furnished education and management about lifestyle choices, medications, and risks. Additionally, Rice expects a higher rate of controlled diabetes among community members with the chronic disease.

Starting Point/Baseline:
The current community does not have a certified diabetes teaching center. Residents within the Rice Hospital District currently must travel long distances or rely on primary care physicians for specific education related to diabetes management and prevention. A large portion of the population is both unable to travel and do not maintain an established relationship with a primary care physician. Approximately 535 patients Rice treats are diagnosed with diabetes, and Rice expects that many more have uncontrolled blood sugar (“pre-diabetic”), leading Rice to predict a target population of at least 2500 patients. Of those diagnosed with diabetes, 25% are Medicaid/uninsured.

Rationale:
Colorado County residents will benefit from primary care providers educating at-risk patients on how to prevent the onset of Type II Diabetes and providing disease management best-practices to those suffering from diabetes already. The prevalence of diabetes increases annually around the State, and this project will further address Colorado County’s rate of premature death and poor physical health days, which exceed the statewide rate.

Specifically, 15% of Colorado County residents receiving care are not being screened for diabetes. Nearly 1/3 of adult residents are obese, and 31% of the population engages in physical inactivity, both of which are linked to the onset and exacerbation of diabetes. Finally, the County has a higher rate of preventable hospital stays than the State wide average and Harris County, some of which are related to diabetes.
Project Components:
This project will address the core requirement of this project option which is to establish self-management programs and wellness using evidenced-based designs.

Milestones and Metrics:
The following milestones and metrics were chosen for the Rice Certified Diabetes Teaching Center project based on the core component and the needs of the target population:
Process Milestones: P-1 (P-1.1); P-3 (P-3.1)
Improvement Milestones: I-6 (I-6.1); I-8 (I-8.1)
Unique community needs assessment numbers:
CN.1, CN.4, CN.10, & CN.12.

Related Category 3 Outcome Measure(s):
OD-1 Primary Care and Chronic Disease Management, IT-1.10 Diabetes care: HbA1c poor control (>9.0%); Unique project identifier 212060201.3.4

Reasons/rationale for selection the outcome measures:
Rice chose this Category 3 Outcome because one of the goals of the Certified Diabetes Teaching Center is to assist patients in managing this chronic disease. When a diabetic’s blood sugar is properly and regularly managed, the risk of being admitted to the hospital for diabetes related complications is reduced greatly. For example, when patients manage their glucose levels they are able to reduce micro-vascular and neuropathic complications of type 1 and type 2 diabetes.

Avoiding the hospital stays and other potential consequences of uncontrolled blood sugar (blindness, amputation, etc) is both beneficial for patient short- and long-term health outcomes (less exposure to infection and hospital-based complications, as well as invasive interventions for the related health consequences), and beneficial for the health care delivery system by reducing costs.

Relationship to other Projects:
This project is related to the following Rice projects: Chronic Disease Outreach, establishing the Wallis Clinic and Reducing Inappropriate use of the ED. These projects will work in tandem, creating a comprehensive approach to managing diabetes.

Relationship to Other Performing Providers’ Projects in the RHP:
Healthcare treatment cannot focus to only the acute or chronic encounter and properly treat the patient. It is critical that our region focuses to patient education and community education to ensure a proactive and responsive approach to healthcare needs. The education models represented in the Region 3 RHP plan can be identified in the Initiative Grid (addendum) and all focus to outcome measures such as appropriate utilization, patient satisfaction scores, and standalone chronic condition scores such as diabetes and asthma.
Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

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

1. Managing chronic disease prior to the onset of acute or emergent conditions is a patient-centered and cost-centered goal under the Waiver, which this project will address head-on by providing early intervention, patient education, and provider monitoring of this chronic disease.

2. Due to the County’s high rate of obesity and physical activity, there are likely many patients suffering from pre-diabetes or uncontrolled diabetes. Rice needs to first identify these patients (which will mean providing screening to all patients, and engaging new patients to visit the Center for screening). Rice then needs to determine how to have the maximum impact on the lifestyle choices made by the Center’s patients by using innovative and evidence-based methods for communicating with and monitoring patient success at preventing and/or controlling the condition.

3. Implementing the Center will require a great deal of investment. Specifically, staff time will need to be dedicated to planning and implementing the development of the Center, seeking Certification, and operating the Center. Rice will need to identify space and start-up costs, as well as ways to engage stakeholders in the community (providers, patients, social groups).
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>IT-1.10</th>
<th>Diabetes care: HbA1c poor control (.9.0%)-NQF 0059</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>

**Milestone 1** [P-1] Conduct an assessment of health promotion programs that involve community health workers at the local and regional level

**Metric 1** [P-1.1] Document regional assessment
Baselines/Goals: Rice will research accreditation requirements and steps towards establishing a Certified Diabetes Teaching Center. Data Source: Rice’s assessment and summary of findings.

**Milestone 1 Estimated Incentive Payment:** $37,117

**Milestone 2** [P-3] Implement, document and test an evidence-based innovative project for targeted population

**Metric 1** [P-3.1] Document implementation strategy and testing outcomes
Baselines/Goals: Rice will establish the Certified Diabetes Teaching Center and begin identifying and working with those at-risk in the Colorado County community. Data Source: Evidence of implementation and certification received

**Milestone 2 Estimated Incentive Payment:** $40,493

**Milestone 3** [I-6] Identify percent of patients in defined population receiving intervention consistent with evidence-based model (Rice will determine the impact of the Certified Diabetes Teaching Center for at-risk community members in Colorado County.)

**Metric 1** [I-6.1]: Defined population with increased patients receiving intervention
Baselines: Rice expects to provide interventions to 600 diabetic and pre-diabetic patients in DY3. In DY4, Rice expects that number to have increased to 600 in DY4. Data Source: Patient records

**Milestone 3 Estimated Incentive Payment:** $40,611

**Milestone 4** [I-8] Increase access to health promotion programs and activities using innovative project option. (Rice will increase the target diabetic and pre-diabetic population of Colorado County reached by the center by 10% over the baseline.)

**Metric 1** [I-8.1]: Increase percentage of target population reached by the project in Colorado County.

Baseline: Rice expects to provide interventions to 600 diabetic and pre-diabetic patients in DY4. In DY5, Rice will target an increase of 200 additional patients receiving interventions in DY5 (estimated to result in 800 patients receiving interventions).
Data Source: Patient records, other documentation showing targeted population versus those seen at the Center

**Milestone 4 Estimated Incentive Payment:** $33,548

**Year 2 Estimated Milestone Bundle Amount:** $37,117
**Year 3 Estimated Milestone Bundle Amount:** $40,493
**Year 4 Estimated Milestone Bundle Amount:** $40,611
**Year 5 Estimated Milestone Bundle Amount:** $33,548

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $151,769
Spindletop Center
Pass 1
Project Option 2.15.2 - Integrate primary and behavioral healthcare services: design, implement and evaluate projects that provide integrated primary and behavioral health care services

**Unique RHP Project Identification Number:** 096166602.2.1  
**Performing Provider Name/TPI:** Spindletop Center / 096166602

**Project Summary:**

**Provider:** Spindletop Center is a public entity community that provides services for approximately 2900 adult, child, and adolescent behavioral health clients, With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties.

**Intervention:** Spindletop will co-locate primary care clinics in its buildings to facilitate coordination of primary and behavioral healthcare. A mobile clinic will be acquired to provide physical and behavioral health services for our clients in locations other than existing Spindletop clinics. Spindletop will also implement Individualized Self Health Action Plan for Empowerment (“In SHAPE”), a wellness program for individuals with mental illness.

**Need for project:** The Region Community Needs Assessment has identified the need for expanded physical health care. Many behavioral health clients cannot access physical health care because they are uninsured or indigent. Health clinics that serve indigent populations often cannot accept more patients and charge a fee higher than many clients can pay. Some of our behavioral health clients have difficulty arranging transportation for multiple healthcare visits.

**Target Population:** This project is targeted to the 2200 adult mental health clients Spindletop serves. Since 54% of these are Medicaid clients and most of the others are uninsured indigent, almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.

**Expected benefits:** By integrating primary care with Spindletop’s behavioral services, 1500 behavioral health clients per year will have open access to outpatient physical health care and appropriate referrals by the end of DY 5, resulting in improved quality of life and reducing emergency room visits and hospitalizations. For DY 2, the process milestone is to develop the integrated sites as reflected in the number of locations and providers participating in the integration project. In demonstration years 3-5, the improvement milestones will be the number of primary care appointments available.

**Category 3 outcomes:** Spindletop has selected improvement outcome measure OD-6 Patient Satisfaction, IT-6.1, percent improvement over baseline of patient satisfaction scores, (1) patients are getting timely care, appointments, and information. The client survey will be designed to produce comparable data on the client's perspective on care that will allow objective and meaningful assessment of the program in meeting the needs of the clients.
Project Option 2.15.2 - Integrate primary and behavioral healthcare services: design, implement and evaluate projects that provide integrated primary and behavioral health care services

Unique RHP Project Identification Number: 096166602.2.1
Performing Provider Name/TPI: Spindletop Center / 096166602

Project Description:
This project will integrate primary care with the behavioral health care services Spindletop Center (“Spindletop”) provides in order to improve care and access to needed health services for the clients we serve.

Spindletop will co-locate primary care clinics in its existing buildings to facilitate coordination of healthcare visits and communication of information among healthcare providers. In addition, a mobile clinic will be purchased or leased and equipped to provide physical and behavioral health services for our clients in locations other than existing Spindletop clinics. The mobile clinic could also be used to provide physical and behavioral health services during disasters such as hurricanes.

To supplement the benefits of integrating primary care with behavioral health services, Spindletop will implement Individualized Self Health Action Plan for Empowerment (“In SHAPE”), a wellness program for individuals with mental illness. Clients will receive proactive, ongoing care that keeps them healthy and empowers them to self-manage their conditions in order to avoid their health worsening and needing ED or inpatient care.

Goals and Relationship to Regional Goals:
This project relates to the Region 3 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

Challenges:
Although Spindletop currently provides basic care such as labs and screenings for drugs, pregnancy, glucose and lipid profiles, we have not expanded other physical health care services due to funding limitations. Hiring or contracting for primary care providers may be challenging as well. Spindletop will initially use one of its current physicians to provide primary care two days a week in addition to the behavioral health services she provides.

5-Year Expected Outcome for Provider and Patients:
By integrating primary care with Spindletop’s behavioral services, 1500 behavioral health clients per year will have open access to outpatient physical health care and appropriate referrals by the end of demonstration year 5. We will begin the project by providing primary health care two days a week in DY3 and add another day each year, resulting in primary care services offered four days per week by year 5. Note that these outcomes are for both Regions 2 and 3 since this project spans these two areas.

Addressing the physical health needs of clients will result in improved quality of life for these clients as well as reducing emergency room visits and hospitalizations for more severe illnesses and diseases that occur when physical health is neglected.
Starting Point/Baseline:
Spindletop Center currently provides behavioral health services for primarily indigent or Medicaid-eligible clients who have schizophrenia, bipolar disorder, and major depression. We have space in our existing facilities to co-locate primary care providers. A need has been identified to provide primary care for our clients in the same location that they receive behavioral health services. Scheduling, billing, and electronic health records systems are already in place for our clients and could be adapted for integration with primary care services.

Rationale:
Behavioral health clients have a high incidence of high blood pressure, cholesterol, obesity, diabetes, and other severe illnesses that shorten their life spans by 25 years compared to the general public. They are frequently high utilizers of hospital emergency departments because they do not have access to regular physical health care.

The Region 3 Community Needs Assessment has identified the need for expanded and integrated physical and behavioral health care. Spindletop Center has determined that many of our behavioral health clients do not have access to physical health care because they are uninsured or lack funds to pay for these services. Health clinics that serve indigent populations frequently do not have capacity to accept more patients and charge a fee higher than many clients are able or willing to pay. Some of our behavioral health clients have difficulty arranging transportation for multiple healthcare visits. Co-locating primary care providers in our behavioral health facilities, providing a mobile clinic, and coordinating healthcare appointments will increase the likelihood that our clients will receive the physical health care they need.

The primary care/behavioral health integration proposed in this plan relates to community needs CN.1, CN.2, CN.5, and CN.10.

This project represents a new initiative for Spindletop. No U.S. Department of Health and Human Services funding is received for this program.

Project Components:
Components of the project include the following:

- Facilities will be adapted for co-locating primary care services.
- A mobile clinic will be purchased and equipped to provide primary and behavioral health care.
- Medical professionals and support staff will be hired or contracted to provide the primary care services.
- InSHAPE health mentors will be hired and trained to work one-on-one with behavioral health clients for education, planning, coaching, and measuring progress.
- For the InSHAPE program Spindletop will partner with local wellness and fitness centers to help behavioral health clients navigate the available opportunities to improve their health condition.
- Protocols will be established for joint scheduling, shared information and treatment plans, and referrals.
- Spindletop’s existing electronic health record system will either be expanded to accommodate physical health data if primary care providers are hired as employees or will be integrated with outside systems if contracted providers are utilized for primary care.
- Spindletop’s current medical staff meetings will be expanded to include primary care providers and discussions of primary care issues at least monthly.
- A system of reporting primary care utilization and outcomes will be developed.
- Ongoing quality assessments will be done to provide feedback for impact and improvements.

**Milestones & Metrics:**
For demonstration year 2, the process milestone is to develop the integrated sites as reflected in the number of locations and providers participating in the integration project.

In demonstration years 3-5, the improvement milestones will be the number of primary care appointments available. Adding 500 appointments each year will increase the number of available appointments to 1500 by the end of demonstration year 5. The number of additional appointments is for both Regions 2 and 3.

**Related Category 3 Outcome Measure(s):**
Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores. (1) patients are getting timely care, appointments, and information. Since the goal of this project is to provide expanded primary care for our behavioral health clients, measuring the availability and timeliness of physical health care and appointments that meet clients’ needs is important. If clients are satisfied with the service, they will be more likely to access primary care that will lead to improved physical health.

**Relationship to Other Projects and Measures:**
This project relates to Spindletop’s Region 2 project to enhance behavioral health training #096166602.2.4 as techniques implemented in that plan may be applied to this program. The project to provide specialty behavioral health care #096166602.1.1 is also related as more clients could receive primary care as well; although this is a Region 2 project, it will also expand care in Region 3

**Relationship to Other Performing Providers' Projects and Measures:**
Other providers in the region are expanding behavioral health capacity and integrating behavioral and physical health. Spindletop’s project will complement those activities.

The cohabitation of primary care and behavioral health is an important focus of our region in order to treat the patient base with comprehensive physical and behavioral healthcare issues. There are multiple initiatives in our RHP plan that address this need and all can be found on the Region 3 Initiative Grid in the addendums. The outcome measures focused to screening measures and access of the patient base.

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

**Project Valuation:**
Spindletop considered several factors in valuing this project including reductions in costs associated with emergency room visits and hospitalizations for diseases and illnesses. Improving the physical health of behavioral health clients should reduce the number of ED visits and the occurrences of hospitalizations. The average cost of an ED visit in Spindletop’s area is $1,265; average cost of a cardiology-related hospital stay is about $16,000.
Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Since behavioral health clients have a high incidence of severe illnesses that shorten their life spans by 25 years compared to the general public, any programs that improve their mental and physical health should increase both the length and quality of their lives.
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Spindletop Center</th>
<th>096166602</th>
</tr>
</thead>
<tbody>
<tr>
<td>096166602.3.1</td>
<td>OD-6 IT-6.1 (1)</td>
<td>Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td>(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong></td>
<td>(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td><strong>Milestone 1</strong> P-5: Develop integrated sites reflected in number of locations and providers participating in the integration project</td>
<td><strong>Milestone 2</strong> I-X: Expand primary care available appointments</td>
<td><strong>Milestone 3</strong> I-X: Expand primary care available appointments</td>
<td><strong>Milestone 4</strong> I-X: Expand primary care available appointments</td>
</tr>
<tr>
<td><strong>Metric 1</strong> P-5.2: Goal: Number of primary care providers newly located in behavioral health settings Baseline/Goal: 1 primary care provider Data Source: Employment records and/or contracts</td>
<td><strong>Metric 1</strong> [I-X.1]: Baseline/Goal: Number of primary care appointments available: 500 primary care appointments Data Source: Scheduling records</td>
<td><strong>Metric 1</strong> [I-X.1]: Baseline/Goal: Number of primary care appointments available: additional 500 primary care appointments over prior year Data Source: Scheduling records</td>
<td><strong>Metric 1</strong> [I-X.1]: Baseline/Goal: Number of primary care appointments available: additional 500 primary care appointments over prior year Data Source: Scheduling records</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $293,611</td>
<td>Milestone 3 Estimated Incentive Payment: $314,096</td>
<td>Milestone 4 Estimated Incentive Payment: 303,476</td>
<td></td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $267,378</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Milestone Bundle Amount: $267,378</strong></td>
<td><strong>Year 2 Estimated Milestone Bundle Amount: $293,611</strong></td>
<td><strong>Year 4 Estimated Milestone Bundle Amount: $314,096</strong></td>
<td><strong>Year 5 Estimated Milestone Bundle Amount: $303,476</strong></td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $1,178,561</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Project Option: 2.17.1 – Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Partial Hospitalization Program

**Unique RHP Project Identification Number:** 181706601.2.1  
**Performing Provider Name/TPI:** St. Joseph Medical Center/181706601

**Project Description:**  
St. Joseph Medical Center proposes to expand services to individuals that have a mental health and/or substance abuse disorder through a Partial Hospitalization Program.

**Provider:**  
St. Joseph Hospital is a 792 licensed facility. Located in the heart of downtown Houston, St. Joseph’s Hospital has provided medical and psychiatric care to Houstonians for 125 years.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payer Mix: Overall Hospital (%)</th>
<th>Patient Payer Mix: Psychiatry (%)</th>
<th>Patient Demographics (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER visits- 29,155</td>
<td>1.18 - Commercial</td>
<td>2.27 - Commercial</td>
<td>Caucasion – 33.47</td>
</tr>
<tr>
<td>Emergency visits- 173,263</td>
<td>18.76 - Managed Care</td>
<td>8.77 - Managed Care</td>
<td>Black – 37.59</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>19.28 - Managed</td>
<td>18.40 - Managed</td>
<td>Hispanic – 11.51</td>
</tr>
<tr>
<td>Admissions - 3,518</td>
<td>16.34 - Managed</td>
<td>3.05 - Managed</td>
<td>Asian - .44</td>
</tr>
<tr>
<td>Med-surg admits – 7049</td>
<td>15.09 - Medicaid</td>
<td>10.41 - Medicaid</td>
<td>American</td>
</tr>
<tr>
<td></td>
<td>20.78 - Medicare</td>
<td>35.61 - Medicare</td>
<td>Indian/Native</td>
</tr>
<tr>
<td></td>
<td>8.37 - Charity</td>
<td>21.48 - Charity</td>
<td>American - .38</td>
</tr>
</tbody>
</table>

**Intervention(s):**  
In this program we will only take voluntary patients and patients must agree to the program rules. All patients are seen by a psychiatrist, psychiatric residents and a RN. They attend four “core” groups per day ran by a licensed therapist. The program runs from the hours of 9:00 to 3:00 and a small breakfast, lunch and snacks are provided.

**Need for the project:**  
Within the Houston community, there are several similar programs servicing the outlying areas. Few programs of this sort assist those clients in or around the Downtown community. Many shelters and low-income type agencies are housed in and around St Joseph’s Hospital.

**Target Population:**  
The program will serve both clients discharging from the inpatient unit and also clients coming from outside referral sources.
Category 1 or 2 expected patient benefits:
Our goal is to provide the “best” model for the patients in this program (typically lower functioning individuals with a GAF below 40). To do this, we are investigating the best evidence-based models and implementing a model within the next 6 months. We project that by end of DY2 - we should achieve a census of 22 patients, by end of DY3 - we should be able to reach a census of 31 patients, by close of DY4 – we will reach a census of 40 total patients and by close of DY 5 we will provide services to 50 patients. Additionally, we estimate that we will potentially provide services of up to 20% of the total patients being either the Indigent or Medicaid population.

Related Category 3 Outcome Measure(s):
IT-1.18 Follow Up after Hospitalization for Mental Illness NQF 0576
Project Option: 2.17.1 – Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Partial Hospitalization Program

Unique RHP Project Identification Number: 181706601.2.1
Performing Provider Name/TPI: St. Joseph Medical Center/181706601

Project Description:
*St. Joseph Medical Center proposes to expand services to individuals who have a mental health and/or substance abuse disorder through a Partial Hospitalization Program.*

The plan and goal for this program is to expand services within the community for the Partial Hospitalization Program at St. Joseph Medical Center. Many times, clients who are functioning at or below a GAF of 40 (CMS recommendation for this level of care) do not follow through with their care recommendations including medication compliance, living situation stability, therapy and aftercare needs. This in turn results in a high level of recidivism and/or re-admissions that having a partial program helps correct.

Through the ongoing efforts of wrap-around services such as a Partial Hospitalization Program (PHP), clients are able to attend groups, maintain and be monitored with their medication compliance, and have support in communication with their current residential setting. To enhance compliance, transportation is provided to/from the patient’s residence.

Many patients in the PHP programs are participants in medicare programs and are unable to remain compliant with their care post inpatient care. Many underinsured in the Houston area (Medicaid HMO) are unable to access care and become non-compliant with their medications and over utilize inpatient care. It is believed that with a collaborative effort with MHMRA, these patients could have their needs met better through a Partial program that ensures compliance by monitoring them daily (Monday-Friday) and ensuring they participate in the program by providing transportation to this vulnerable population.

Each patient in the PHP is initially evaluated to determine if they are appropriate and willing to be compliant with the program- therefore, in this program we only take voluntary patients and they must agree to the program rules. All patients are seen by a psychiatrist, psychiatric residents and a RN. They attend four “core” groups per day run by a licensed therapist. The program runs from the hours of 9:00 to 3:00 and a small breakfast, lunch and snacks are provided.

Goals and Relationship to Regional Goals:

Project Goals:
- Expand PHP services to individuals in the Houston metro area
- Expand Transportation to/from the PHP for those patients requiring care from our PHP
- Collaborate with other area agencies to provide services for their clients and offer better wrap-around services to meet the needs within the community
- Increase the percentage of patients who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter
or partial hospitalization with a mental health practitioner. Rate reported will be those patients with follow up visits within 30 days of discharge.

- This project meets the following Region 3 goals:
  - Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

Challenges:
1. Locating, hiring and training staff appropriate for the PHP (RN’s, therapists and Techs)
2. Higher level of scrutiny on all levels of PHP due to multiple concerns with other providers which will require the Director be involved in and attending semi-annual conferences on compliance and regulatory concerns.
3. Physician coverage issue may be an issue for any off site locations

The facility will address these challenges by:
1. Work through Human Resources to advertise, identify and help in the hiring/training portion of these issues.
2. Attendance at the semi-annual conferences on compliance and regulatory concerns held by the state. Additionally, an internal auditor will assist with ensuring compliance through regular chart and programmatic audits.
3. Facility will identify community practitioners willing to provide physician coverage and partner with the facility.

5-Year Expected Outcome for Performing Provider and Patients:
- Patient expansion will reach 50 ADC (Average Daily Census) through a gradual ramp-up
- Patients will participate in evidence-based programming
- Ongoing feedback from both the patients and community partners will help determine best practices and consistent re-evaluation of the program will occur

We project that by end of DY2 - we should achieve a census of 22 patients, by end of DY3 - we should be able to reach a census of 31 patients, by close of DY4 – we will reach a census of 40 total patients and by close of DY 5 we will provide services to 50 patients. Additionally, we estimate that we will potentially provide services of up to 20% of the total patients being either the Indigent or Medicaid population.

Starting Point/Baseline:
- We currently have one van which is operational providing transportation to the clients within the program
- Staffing currently includes one full time RN, one full-time therapist, one tech/driver along with a working manager
- Current Average Daily Census is: 5
Rationale:
Many of the clients identified as needing this service are currently being readmitted to the facility for inpatient care on a regular basis. The goal of this program is to decrease recidivism; increase compliance to discharge plans and help ensure the patient is more functional in an outpatient setting. Most clients admitted to a partial program have a GAF (global assessment of functioning – as noted in the DSM4 Manual) of 40 or below. Typically, this means that they have poor psycho-social skills and low compliance to discharge plans and poor follow through with their medication regimen.

Project Components:
Through the Partial Hospitalization Program, we propose to meet all required project components listed below and believe that the selected milestones and metrics relate to project components.

a) Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, ambulatory care, behavioral health and community-based non-medical supports
b) Conduct an analysis of the key drivers of 30-day hospital readmissions for behavioral health conditions using a chart review tool and patient and provider interviews.
c) Identify baseline mental health and substance abuse conditions at high risk for readmissions
d) Review best practices for improving care transitions form a range of evidence-based or evidence-informed models
e) Identify and prioritize evidence-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions
f) Implement two or more pilot interventions in care transitions targeting one or more patient care units or a defined patient population.
g) Conduct quality improvement for project using methods such as rapid cycle improvement.

Unique community need identification number the project addresses:
• CN-3 – Inadequate access to behavioral health care

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project will enhance the inpatient services by decreasing the high number of readmissions to the inpatient unit – thus increasing the ability for other patients to have access to the limited number of inpatient beds in the Houston community. Additionally, it will help current patients be more successful in an outpatient setting. Success is determined by being compliant with the discharge recommendations made by the psychiatrist and treatment team.

Related Category 3 Outcome Measure(s):
OD-1 Primary Care and Disease Management:
IT-1.18 Follow Up After Hospitalization for Mental Illness – NQF 0576
• Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge
Reasons/rationale for selecting the outcome measures:
The reason for selection of the category 3 outcome measure is that it is extremely important with this patient population to select evidence-based protocols that are respected within the psychiatric community. Years 4 and 5 were selected to be the most beneficial outcome measure as it is important to identify the needs of the high risk patients and track this data.

Relationship to other Projects:
The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

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

Project Valuation:
This project has an assigned value of $8,205,536 for the four years starting with DY2 – DY5. Extensive analysis was initiated to derive at this value. Project costs (capital and operational) and community benefits were among the factors used to create the valuation. Modest renovations to an existing space in the Psychiatric building (Cullen Building) must be made to accommodate the expected OP census. Renovation costs are estimated at $250,000 (capital). In addition, a medical director must be paid to care for these patients. Also, clinical staff must be employed to conduct the non-physician care associated with this service line. In addition, a transport van must be purchased to increase our census as this project expects ($40,000 capital estimated).
### Design, Implement, and Evaluate Interventions to Improve Care Transitions from the Inpatient Setting for Individuals with Mental Health and/or Substance Abuse Disorders: Partial Hospitalization Program

**St. Joseph’s Medical Center**

**Follow-Up After Hospitalization for Mental Illness – NQF 0576**

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

<table>
<thead>
<tr>
<th>181706601.3.1</th>
<th>IT-1.18</th>
</tr>
</thead>
</table>

#### Year 2 (10/1/2012 – 9/30/2013)

| Milestone 1 [P-X]: Conduct a needs assessment of evidence based practices | Milestone 2 [P-6]: Identify evidence-based frameworks that support seamless care transitions and impact preventable 30-day readmissions. Metric 1 [P-6.1] Selection of an evidence based framework Baseline/Goal: Select evidence based framework Data Source: Meeting minutes displaying the selection of evidence based framework | Milestone 3 [I-37]: Improvement in percentage of “High Risk” patients with customized care plans before discharge Metric 1 [I-37.1]: X percent improvement in percentage of “High Risk” patients with customized care plans before discharge Baseline: Baseline will be established in year 3 after evidence based framework is established Goal: 25% percent improvement in percentage of “High Risk” patients with customized care plans before discharge Data Source: Medical Records, Program Documentation, E.H.R. | Milestone 4 Estimated Incentive Payment: $1,635,452 |

| Milestone 1 Estimated Incentive Payment: $2,050,000 | Milestone 2 Estimated Incentive Payment: $2,250,382 | Milestone 3 Estimated Incentive Payment: $2,269,702 | Milestone 4 Estimated Incentive Payment: $1,635,452 |

#### Year 3 (10/1/2013 – 9/30/2014)

| Milestone 1 [P-X]: Conduct a needs assessment of evidence based practices | Milestone 2 [P-6]: Identify evidence-based frameworks that support seamless care transitions and impact preventable 30-day readmissions. Metric 1 [P-6.1] Selection of an evidence based framework Baseline/Goal: Select evidence based framework Data Source: Meeting minutes displaying the selection of evidence based framework | Milestone 3 [I-37]: Improvement in percentage of “High Risk” patients with customized care plans before discharge Metric 1 [I-37.1]: X percent improvement in percentage of “High Risk” patients with customized care plans before discharge Baseline: Baseline will be established in year 3 after evidence based framework is established Goal: 25% percent improvement in percentage of “High Risk” patients with customized care plans before discharge Data Source: Medical Records, Program Documentation, E.H.R. | Milestone 4 Estimated Incentive Payment: $1,635,452 |

| Milestone 1 Estimated Incentive Payment: $2,050,000 | Milestone 2 Estimated Incentive Payment: $2,250,382 | Milestone 3 Estimated Incentive Payment: $2,269,702 | Milestone 4 Estimated Incentive Payment: $1,635,452 |

#### Year 4 (10/1/2014 – 9/30/2015)

| Milestone 1 [P-X]: Conduct a needs assessment of evidence based practices | Milestone 2 [P-6]: Identify evidence-based frameworks that support seamless care transitions and impact preventable 30-day readmissions. Metric 1 [P-6.1] Selection of an evidence based framework Baseline/Goal: Select evidence based framework Data Source: Meeting minutes displaying the selection of evidence based framework | Milestone 3 [I-37]: Improvement in percentage of “High Risk” patients with customized care plans before discharge Metric 1 [I-37.1]: X percent improvement in percentage of “High Risk” patients with customized care plans before discharge Baseline: Baseline will be established in year 3 after evidence based framework is established Goal: 25% percent improvement in percentage of “High Risk” patients with customized care plans before discharge Data Source: Medical Records, Program Documentation, E.H.R. | Milestone 4 Estimated Incentive Payment: $1,635,452 |

| Milestone 1 Estimated Incentive Payment: $2,050,000 | Milestone 2 Estimated Incentive Payment: $2,250,382 | Milestone 3 Estimated Incentive Payment: $2,269,702 | Milestone 4 Estimated Incentive Payment: $1,635,452 |

#### Year 5 (10/1/2015 – 9/30/2016)

| Milestone 1 [P-X]: Conduct a needs assessment of evidence based practices | Milestone 2 [P-6]: Identify evidence-based frameworks that support seamless care transitions and impact preventable 30-day readmissions. Metric 1 [P-6.1] Selection of an evidence based framework Baseline/Goal: Select evidence based framework Data Source: Meeting minutes displaying the selection of evidence based framework | Milestone 3 [I-37]: Improvement in percentage of “High Risk” patients with customized care plans before discharge Metric 1 [I-37.1]: X percent improvement in percentage of “High Risk” patients with customized care plans before discharge Baseline: Baseline will be established in year 3 after evidence based framework is established Goal: 25% percent improvement in percentage of “High Risk” patients with customized care plans before discharge Data Source: Medical Records, Program Documentation, E.H.R. | Milestone 4 Estimated Incentive Payment: $1,635,452 |

| Milestone 1 Estimated Incentive Payment: $2,050,000 | Milestone 2 Estimated Incentive Payment: $2,250,382 | Milestone 3 Estimated Incentive Payment: $2,269,702 | Milestone 4 Estimated Incentive Payment: $1,635,452 |

#### Total Estimated Incentive Payments for 4-Year Period

(add milestone bundle amounts over DYs 2-5): $8,205,536

**Regional Healthcare Partnership Plan**

**Region 3**

**1450**
Project Option: 2.15.1 – Design, implement and evaluate interventions to improve care transitions from the mental health and/or substance abuse disorder

Unique RHP Project Identification Number: 181706601.2.2
Performing Provider Name/TPI: St Joseph Medical Center/181706601

Project Description:
This proposed unit will meet the needs of adults (ages 18 and above) who have a primary medical diagnosis with a co-occurring psychiatric diagnosis. These patients will be treated on a unit specifically designed to meet both diagnosis within the hospital. It will be a separate and distinct unit – comprised of 12 beds.

Provider:
St. Joseph Hospital is a 792 licensed facility. Located in the heart of downtown Houston, St. Joseph’s Hospital has provided medical and psychiatric care to Houstonians for 125 years.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payer Mix: Overall Hospital (%)</th>
<th>Patient Payer Mix: Psychiatry (%)</th>
<th>Patient Demographics (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER visits- 29,155</td>
<td>1.18- Commercial</td>
<td>2.27- Commercial</td>
<td>Caucasian – 33.47</td>
</tr>
<tr>
<td>Emergency visits- 173,263</td>
<td>18.76- Managed Care</td>
<td>8.77- Managed Care</td>
<td>Black – 37.59</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>19.28- Managed Medicaid</td>
<td>18.40- Managed Medicaid</td>
<td>Hispanic – 11.51</td>
</tr>
<tr>
<td>Admissions - 3,518</td>
<td>16.34- Managed Medicare</td>
<td>3.05- Managed Medicare</td>
<td>Asian - .44</td>
</tr>
<tr>
<td>Med-surg admits – 7049</td>
<td>15.09- Medicaid</td>
<td>10.41- Medicaid</td>
<td>American</td>
</tr>
<tr>
<td></td>
<td>20.78- Medicare</td>
<td>35.61- Medicare</td>
<td>Indian/Native</td>
</tr>
<tr>
<td></td>
<td>8.37 - Charity</td>
<td>21.48 - Charity</td>
<td>American - .38</td>
</tr>
</tbody>
</table>

Intervention(s):
The concept would be to have a strong emphasis on the medical issues while also focusing on the mental health needs of the clients at the same time. This medical psychiatric nursing and support team will be trained in trauma-informed care models and the interface between medical and psychiatric problems.

Need for the project:
Currently, there are two medical-psychiatric units in Houston. There is a unit at Ben Taub and another unit at Memorial Southwest. According to statements both by their own staff and from referrers within the community, these units stay consistently full.

Target Population:
All eligible patients within the St Joseph Hospital system could benefit from this program.

Category 1 or 2 expected patient benefits:
Our goal is to provide the “best” model for co-occurring diagnosis – which will include investigating the best evidence-based models and implementing the one selected. We will hire
and train staff interested in working with individuals with co-occurring diagnosis and also select and pay a psychiatrist to attend to these clients. Expect to serve 429 patients in DY4 and DY 5 448 patients.

**Related Category 3 Outcome Measure(s):**
IT-9.2 – ED appropriate utilization (standalone measure) They will be established to determine a 3-month outcome post discharge from patients leaving this program.
Project Option: 2.15.1 – Design, implement and evaluate interventions to improve care transitions from the mental health and/or substance abuse disorder- Create a Med/Psych Unit on the campus of St Joseph Medical Center

Unique RHP Project Identification Number: 181706601.2.2
Performing Provider Name/TPI: St Joseph Medical Center/181706601

Project Description:
Numerous studies have demonstrated the high prevalence of co-occurring mental health and medical issues in the United States. Due to a severe shortage of inpatient programs which are able to address these co-occurring needs, typically one of two things occurs in the Houston market.

1. The patient is treated for their medical condition and their mental health concerns go largely unaddressed or they are placed in a medical bed with a “sitter” to ensure their safety while also decreasing risk and liability. Once again, this does not address those mental health issues or needs but instead, their treatment is merely delayed.
2. The patient is unable to access care for their mental health issues as their co-occurring medical issues are part of an exclusionary criteria in most free-standing psychiatric hospitals.

Currently, there are two medical-psychiatric units in Houston. There is the unit at Ben Taub and another unit at Memorial Southwest. According to statements both by their own staff and from referrers within the community, these units stay consistently full and it is virtually impossible to get a patient from another facility to either one of these units.

This proposed unit will meet the needs of adults (ages 18 and above) who have a primary medical diagnosis with a co-occurring psychiatric diagnosis. The patients will be screened and admitted by a unit manager, who will either be a Licensed Clinical Social Worker or RN. The unit manager will report to the psychiatric director and manage the daily milieu. The unit will be staffed to include two psychiatric social workers who will conduct the therapeutic interventions and make the discharge plans in collaboration with the attending physician.

The concept would be to have a strong emphasis on the medical issues while also focusing on the mental health needs of the clients at the same time. This medical psychiatric nursing and support team will be trained in trauma-informed care models and the interface between medical and psychiatric problems. They will implement best practices to meet the needs of this particular type of clientele.

Goals and Relationship to Regional Goals:
Project goals:
- Evaluate and determine the “best” model for co-occurring conditions and open a program to meet those needs
- Determine most effective ways to assist patients in their recovery process from both the medical and psychiatric challenges that they face

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

5 year expected outcome for Performing Provider and patients:
• Within 5 years, we will have an operational and clinically sound program for the medical-psychiatric patient at St. Joseph’s Behavioral. This program will be managed by a skilled clinician who will ensure that all quality, regulatory and productivity goals are met.
• Determine optimal number of beds with a ramp up to financially cover the % of admissions – as specified in the matrix. Community need has already been determined – clearly, there is a severe lack of services in the city for the medical/psychiatric patient. As of the date of this proposal, there is no known other proposals to cover a medical/psychiatric project.
• Complete renovation, advertise and open a 12 bed unit to address the co-occurring needs of the medical and psychiatric patient

Challenges and how addressed:
• Renovation time frames and opening program to meet the needs of these clients
• Determining exclusionary criteria and processes for accepting transfers from other facilities
• Medical staff integration and operational issues
• Locating nursing and clinical staff appropriate for meeting the needs of this population of patients.
• Understanding licensing standards and initiating licensure, forms and policy and procedures for this program.

Ways to be addressed:
• Renovation plans are easily prepared and upon acceptance of this program can proceed forward
• Exclusionary criteria- will be developed in cooperation with the medical staff and a medical director, who will be selected – other examples exist from the other units and can be utilized as a template
• Medical staff integration will take place immediately and with the assistance of an identified medical director
• Human resources at the hospital will assist with the hiring, training and selection of the appropriate staff for this program
• Licensing standards- the compliance and risk departments within the hospital can be called on to assist with all these issues.

Rationale:
Currently, these clients are being admitted to general floors within the hospital and are “blended” into rooms with patients who may/may not have mental health issues. This project will bring all these patients into one area to better meet both their mental health needs and medical needs in a more appropriate integrated setting.
Listed below are some facts regarding co-occurring diagnosis issues. These were taken from several sources and source information can be found through the Mental Health America website. Based upon the literature review seen below, there are clear indicators that there is a strong correlation between medical illnesses and psychiatric diagnosis. With that in mind, it would appear that treatment of these needs in an appropriate setting whereby both issues are addressed concurrently makes sense. This proposal is to treat both issues concurrently in the most appropriate setting. Most free-standing psychiatric facilities do not feel adequately equipped to address the medical issues and in-fact list the medical issues on their exclusionary admitting criteria. This leaves virtually (with the exception of two units) no options for people in the Houston community to go for treatment.

After much due diligence, we have identified the number of clients to be served starting with DY2 – June 1 to September at 56. For DY 3, we will serve 281 patients, DY4, 429 patients and DY 5 448 patients. The numbers ensure a ramp up to an ADC (average daily census) of 8 over the course of the four years – accounting for the need to staff, train and hire the appropriate individuals and also to identify the appropriate physician coverage for the unit. Additionally, we estimate that this service line will provide care to the Medicaid/Indigent population of up to 30% of the total volume.

Facts about co-occurring medical/psychiatry (reference: Mental Health America)

- The rate of depression among those with medical illnesses in primary care settings is estimated at five to 10 percent. (2)
  - Among those hospitalized, the rate is estimated at 10 to 14 percent. (2)
- The more severe the medical condition, the more likely that patient will experience clinical depression. (2)
- People with depression experience greater distress, an increase in impaired functioning and less ability to follow medical regimens, thus hindering the treatment of any other medical conditions. (2)
- Medical disorders may contribute biologically to depression.[3]
- Unfortunately, the diagnosis of depression is missed 50 percent of the time in primary care settings. (1)
- Depression occurs in 40 to 65 percent of patients who have experienced a heart attack, and in 18 to 20 percent of people who have coronary heart disease, but who have not had a heart attack. (4)
- After a heart attack, patients with clinical depression have a three to four times greater chance of death within the next six months. (4)
- One in four people with cancer also suffers from clinical depression. (8)
- Depression occurs in 10 to 27 percent of stroke survivors and usually lasts about one year. (6)
- An additional 15-40 percent of stroke survivors experience some symptoms of depression within two months after the stroke. (7)
- One in four people with cancer also suffers from clinical depression. (9)
- People with bipolar disorder are also at higher risk for thyroid disease, migraine headaches, heart disease, diabetes, obesity, and other physical illnesses (2)

Project Components:
We propose to meet all of the required project components as follows:
a) Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community.
b) Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated.
c) Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers
d) Recruit a number of specialty providers (physical health, mental health, substance abuse, etc.) to provide services in the specified locations.
e) Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include:
   • Regular consultative meetings between physical health and behavioral health practitioners;
   • Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners; and/or
   • Shared treatment plans co-developed by both physical health and behavioral health practitioners.
f) Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated electronic health record system or participation in a health information exchange – depending on the size and scope of the local project.
g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.
h) Arrange for utilities and building services for these settings
i) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.
j) Conduct quality improvement for project using methods such as rapid cycle improvement.

Unique community needs identification numbers:
   • CN 3 - Inadequate access to behavioral health care

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

Reasons/rationale for selecting the outcome measures:
The goal is to ensure that all clients are treated in the most appropriate manner for their co-occurring mental health and medical issues. The measure selected would allow us to track if we are accomplishing this goal.

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

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

**Project Valuation:**
Project is valued at $12,623,903 for the four years starting with DY2 – DY5. Extensive analysis was conducted to arrive at this valuation. Benefits to the community include the increase in available beds in the community to which patients with dual diagnoses (behavioral and medical) can be admitted. This coordinated care in the right setting will reduce readmissions, medical complication rates and overall length of stay, saving the unnecessary burdens of treating these patients.
Design, Implement and Evaluate Interventions to Improve Care Transitions from the Mental Health and/or Substance Abuse Disorder by Creating a Med/Psych Unit on the Campus of St Joseph Medical Center NS from the Mental Health and/or Substance Abuse

St Joseph Medical Center

Texas TPI #: 181706601

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>IT-9.2</th>
<th>ED Appropriate Utilization</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 [P-4]:</strong> Assess ease of access to potential locations for project implementation</td>
<td><strong>Milestone 2 [P-7]:</strong> Evaluate and continuously improve integration of primary and behavioral health services</td>
<td><strong>Milestone 3 [P-8]:</strong> Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects.</td>
<td><strong>Milestone 4 [I-8]:</strong> Integrated Services</td>
</tr>
<tr>
<td>Metric 1 [P-4.1]: Access to major roadways, bus routes, or proximity to a large number of individuals who may benefit from services</td>
<td>Metric 1 [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study, act</td>
<td>Metric 1 [P-8.1]: X% of Individuals receiving both physical and behavioral health care at the established locations. Goal: 25% of patients receiving both behavioral and acute care services are in the project setting (429 patients admitted to program)</td>
<td>Metric 1 [I-8.1]: X% of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise. Goal: 50% of individuals with treatment plans developed and implemented with primary care and behavioral health expertise. (448 patients admitted to program)</td>
</tr>
<tr>
<td>Baseline/Goal: Produce a comprehensive report documenting all points above. To continue Milestone 1 each year. Data Source: City/Count data, maps, demographic data relating to prevalence of health conditions</td>
<td></td>
<td>Data Source: Project data, claims and encounter data, medical records</td>
<td>Data Source: Project data, Clinic Registry Data, Claims and encounter records, Patient Records</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment (maximum amount): $1,575,000</td>
<td></td>
<td>Milestone 4 Estimated Incentive Payment: $3,495,697</td>
<td>Milestone 5 Estimated Incentive Payment: $2,516,080</td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan
Region 3
<table>
<thead>
<tr>
<th>181706601.2.2</th>
<th>2.15.1</th>
<th>2.15.1(A-J)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DESIGN, IMPLEMENT AND EVALUATE INTERVENTIONS TO IMPROVE CARE TRANITIONS FROM THE MENTAL HEALTH AND/OR SUBSTANCE ABUSE DISORDER BY CREATING A MED/PSYCH UNIT ON THE CAMPUS OF ST JOSEPH MEDICAL CENTER NS FROM THE MENTAL HEALTH AND/OR SUBSTANCE ABUSE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>St Joseph Medical Center</strong></td>
<td><strong>Texas TPI #: 181706601</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td><strong>181706601.3.2</strong></td>
<td><strong>IT-9.2</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Quality improvement cycles</td>
<td>Data Source: Catalogue of challenges, solutions, tests and progress shared by the participating provider during each bi-weekly interaction</td>
<td>Could be summarized at quarterly intervals</td>
</tr>
<tr>
<td>Goal: Produce project plan and implement PDSA quality improvement cycles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Project Reports include examples of how real-time data is used for rapid cycle improvement to guide continuous quality improvement</td>
<td>Milestone 2 Estimated Incentive Payment: $1,575,000</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $3,150,000</td>
<td>Year 3 Estimated Milestone Bundle Amount: $3,462,126</td>
<td>Year 4 Estimated Milestone Bundle Amount: $3,495,697</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add milestone bundle amounts over DYs 2-5): $12,623,903</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
St. Luke's Episcopal Hospital
Pass 1
**Project Option**  Project Area 2.12: Implement/Expand Transitions Programs

**Functionalities:** Transitional Care for Chronic Disease

**Unique RHP Project ID:** 127300503.2.1

**Performing Provider Name/TPI:** St. Luke’s Episcopal Hospital

**Project Summary:**

Provider:
St. Luke’s Episcopal Hospital (SLEH) is a 850-bed tertiary and quaternary teaching hospital located in the heart of the Texas Medical Center and is home of the Texas Heart® Institute. Founded in 1954 by the Episcopal Diocese of Texas, St. Luke’s is affiliated with multiple nursing schools and three medical schools.

### Volume Statistics - FY2012 (November annualized)

<table>
<thead>
<tr>
<th></th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions</td>
<td>Self-Pay - 4.2%</td>
<td>Caucasian - 48.2%</td>
</tr>
<tr>
<td>Emergency visits</td>
<td>Medicaid and CHIP - 4.0%</td>
<td>African American - 29.8%</td>
</tr>
<tr>
<td>Other Funding</td>
<td>Medicare - 47.6%</td>
<td>Hispanic - 14.4%</td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>Other Funding - 3.2%</td>
<td>Asian - 2.5%</td>
</tr>
<tr>
<td></td>
<td>Commercial Insurance- 41.0%</td>
<td>American Indian - .2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other - 4.9%</td>
</tr>
</tbody>
</table>

### Intervention(s):

The purpose of this project is to build a bridge from the acute inpatient setting to a stable primary care-based medical home for patients with congestive heart failure (CHF). The targeted population is that group of patients with CHF cared for in the SLEH acute inpatient setting for an index admission. The goal is to reduce readmissions.

### Need for the project:

Approximately one fourth of patients discharged from the hospital with congestive heart failure are readmitted within 30 days of discharge. A primary cause for readmission is failure to gain rapid access post discharge to primary care. Evidence suggests that access within the first seven days post discharge can reduce readmission rates by up to 30%.

### Target Population:

All patients discharged from St. Luke’s Episcopal Hospital with congestive heart failure, approximately 6,000 annually.

### Category 1 or 2 expected patient benefits:

Reduction in readmission rate of 30%. Improve reported health days by 25%.

### Category 3 outcomes:

**Outcome Measure:** OD-3/IT-3.2 Potentially Preventable Re-Admissions – 30-day Readmission Rates (PPRs)/Congestive Heart Failure 30-day Readmission Rate

**Outcome Measure:** OD-10 Quality of Life/Functional Status
Project Description:

St Luke’s Episcopal Hospital proposes to provide transitional care services to a targeted population with congestive heart failure (CHF).

The purpose of this project is to build a bridge from the acute inpatient setting to a stable primary care-based medical home for patients with congestive heart failure (CHF). The targeted population is that group of patients with CHF cared for in the SLEH acute inpatient setting for an index admission. The goal is to reduce readmissions.

Goals and Relationship to Regional Goals:

Congestive Heart Failure (CHF) is a high-cost chronic condition which affects many patients and their families in Harris County. It is a debilitating disease, though manageable in a primary care setting.

The goal of this project is to create a medical home structure for CHF patients, allowing them to maintain their health while in the community rather than a facility. For many patients, this will shift treatment from costly inpatient services, to primary care and outpatient settings, reducing costs, while enhancing each patient’s quality of life.

This goal supports the region’s efforts to increase reliance on primary care services, where feasible, and transform the delivery of health care services from one which emphasizes facility-based treatment, to one focused on non-acute care.

Project Goals:

The goal of the project is to reduce inpatient costs for CHF patients by providing comprehensive preventive care outside the hospital.

This project meets the following Region 3 goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure.

Challenges:

The greatest challenge will be to overcome the reliance on the part of patients and providers to treat CHF primarily in an acute care setting. The current system depends on the availability of an ongoing relationship with a primary and/or a specialty care physician to develop a meaningful transitional plan of care. In the absence of this relationship the patient has a much higher probability of an early readmission or ED visit. Furthermore, patient education is offered at a time when the patient is least likely to be receptive - in the midst of acute deterioration. Reinforcement training post discharge is a key element in building and sustaining patient activation.
5-Year Expected Outcome for Provider and Patients:

St. Luke’s expects to see improvements in CHF outcomes, specifically related to hospital admissions and readmissions. By Year 3 we anticipate actively enrolling 750 patients in an aggressive Care Transitions Program and a minimum of 1500 additional patients annually in Years 4 and 5. We project a reduction in 30-day readmissions within this group of 30% by Year 5.

Starting Point/Baseline:

This is a new initiative. A baseline will be developed once the program is operational. Based upon 6000 annual congestive heart failure discharges, we believe that we will be able to capture and enroll approximately 750 patients in the first year of operations (Year 3). Our goal is to expand in subsequent years as we build capability for direct patient care and confidence in our medical staff.

Rationale:

The rationale for the project is to build a bridge from the acute inpatient setting to a stable primary care-based medical home for patients with congestive heart failure (CHF). The targeted population is that group of patients with CHF cared for in the SLEH acute inpatient setting for an index admission.

Project Components:

St. Luke’s will address each of the required core components, including the following.

Review best practices from a range of models - The keys to achieving our goal begin with the development of a Transitional Care Clinic. This approach begins the facilitated patient connection process at the time of an index admission. Transitional Care Clinic based staff will overlap with the acute inpatient staff to reduce failures to coordinate care. This ensures that effective patient education and medications management occurs and brings focus on social barriers that contribute to failure.

A number of interventions aimed at building capacity for transitional care have demonstrated effectiveness (BOOST, Project RED, etc.). Generally based on Dr. Ed Wagner’s model of chronic disease (http://www.grouphealthresearch.org/research/areas/chronic.aspx), a clinic specifically designed to provide access within the first 7 days (or sooner if necessary) can reduce readmissions by up to 30%. The same clinical function can provide interim care until a transition to a stable primary care relationship can occur for patients without an established relationship. Concurrent development of robust relationships with community-based providers provides the connection to stable primary care for at-risk populations.

Conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool - The key driver of ED visits and early readmissions following acute care hospitalization is the failure to manage the inpatient transition to a stable primary care relationship. Access represents the major barrier to receiving stable care. The reasons for poor access can be financial, social or provider availability. The most vulnerable period occurs early following discharge with probability of readmission increasing with time from discharge to initial follow-up appointment. Without ready means of access, the Emergency Room is often the portal of entry. Risk assessment for readmission will be conducted using the IHI STAAR Tool.
Integrate information systems – Data sources will be Epic EHR and claims-based administrative databases (UHC, Crimson) as well as publically reported data sets (Hospital Compare).

Develop system to identify at-risk patients - Risk assessment for readmission will be conducted using the IHI STAAR Tool on admission.

Implement discharge planning and post discharge support - The first post hospitalization visit is the bridge to the next level of care and stable primary care in a medical home. Development of partnership relationships with community-based organizations is so important for patients who have otherwise been disenfranchised. Embedded within the clinical operation are support services to address social determinants such as transportation, in-home support, lifestyle coaching and more traditional interventions such as nutritional status. The integration of services at one site of care ensures necessary collaboration and cooperation to address short-term markers of care process failure, such as ED visits and premature readmissions.

Develop a cross-continuum team - Currently St. Luke’s Episcopal admits approximately 6000 patients annually for heart failure. Each patient would undergo a risk assessment on admission (IHI STAAR Tool) and a specific plan of care unique to each patient would be developed. The focus of the assessment is a determination of transitional care needs and facilitation at time of discharge into a stable primary care relationship. If a relationship currently exists, care will be coordinated with the existing provider focused on access to the first post-discharge visit within 7 days.

If the primary care provider cannot see the patient within seven days, an appointment can be arranged in the Transitional Care Clinic with consent of the patient and in coordination with the primary provider. If the patient does not have a primary care provider, initial follow-up will be through the Transitional Care Clinic where facilitation occurs into a stable primary care relationship, taking into account the patient’s wishes, location of residence, and other social determinants. Community based organizations provide an opportunity for transition to a stable primary care relationship (includes a qualified FQHC).

Conduct quality improvement - Significant focus is on the patient’s assessment of Quality of Life as measured by the CDC-HRQOL, which includes embedded scales for Healthy Days Core Module, Activities Limitations Module, and Healthy Days Symptoms Modules.

The initial phases of the project recognize that short-term measures focused on process metrics may change before major outcomes changes, like readmissions or mortality begin to move. For this reason, days between admissions serves as a directional proxy in the first year of patient enrollment.

Data sources will come from Epic EHR and claims-based administrative databases (UHC, Crimson) as well as publically reported data sets (Hospital Compare). Process improvement methodologies will be based on The Model for Improvement (IHI) and will incorporate other tools as appropriate to include LEAN, Six Sigma, and Statistical Process Control tools. The project will have access to an IHI trained Improvement Advisor as a principle consultant.

Critical success factors and key challenges include:
- Coordinated information flow
- Shared ownership of patient population
- Centralized registry of patients
Optimization from the patient’s perspective
Common shared clinical care pathway
Common formulary

**Milestone & Metrics:**

The following milestones and metrics have been chosen for the transitional care program for CHF patients:
- Process Milestones: P-1, P-2 (P-2.1), P-4, (P-4.1), P-7, (P-7.1), P-9, P-9.1).
- Improvement Milestones: I-11

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

This project is a new initiative for St. Luke’s Episcopal Hospital. The costs associated with providing this transitional care plan will all be new costs to the Hospital. The costs would include labor costs for developing and running the transitional care clinic.

**Unique community need identification number the project addresses:**
- CN.1 Inadequate access to primary care
- CN.2 Inadequate access to specialty care
- CN.9 High rates of preventable hospital readmissions
- CN.10 High rates of preventable hospital admissions

**Related Category 3 Outcomes Measures:**

OD-3 Potentially Preventable Readmissions – 30 day Readmission Rates
IT-3.2 Congestive Heart Failure 30-day Readmission Rate

OD-10 Quality of Life/Functional Status
IT-10.1 Quality of Life

**Reasons/rationale for selecting the outcome measures:**

The impact of this initiative can be measured by tracking readmission rates for the target population and assessing improvements in the patients’ quality of life through use of a validated assessment tool.

**Relationship to other Projects:**

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.
Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region’s health care system.

Project Valuation: The project scope includes all patients with an index admission of congestive heart failure at St. Luke’s Episcopal Hospital. This is anticipated to be approximately 6,000 patients annually. The intervention begins with education upon admission. The care team will also provide information about the services of the Transitional Care Clinic. Prior to discharge, a follow-up appointment will be scheduled within seven days for each patient. In addition, the care team providers will identify if the patient currently has consistent primary care support. If none is identified, the team will assist the patient in finding stable primary care.

All patients identified with CHF will be supported with this intervention; however, specific-focus will be given to those most at-risk, including the underserved and uninsured. By the end of Year 3 we will have actively enrolled 12.5% of the target population (750 patients) in a Care Transitions Program. In subsequent years (Year 4 and Year 5) we will actively enroll an additional 1500 patients per year. Therefore, by the end of Year 5, 3750 patients will be actively enrolled. By year 5, we predict that 30-day readmission rates for patients actively enrolled will decline by 30% over currently reported metrics (National average 24.7%). The goal for 30-day readmission rate is less than 17.3%.

This addresses a high-priority community need due to the incidence of heart disease. The overall community, including Medicaid and indigent patients, will benefit by savings achieved by reducing the unnecessary and costly use of acute hospital services.
Performing Provider: St. Luke’s Episcopal Hospital

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1 – [P-1]:** Develop and publish consensus evidence-based protocols for providers and patients for management of congestive heart failure.

**[P-1.1]. Metric:** Care transitions protocols
Goal: Develop protocols
Data Source: Submission of protocols, Care transitions program materials

**Milestone 1:** Estimated incentive payment (Maximum Amount): $1,192,718

**Milestone 2 – [P-4]:** Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge

**[P-4.1]. Metric:** Care transitions assessment
Goal: Develop map identifying clinical resources and referral acceptance status.
Data Source: Care transitions assessment and resource planning documents and resource map.

**Milestone 5 – [P-2]:** Implement standardized care transition processes

**[P-2.1]. Metric:** Care transitions policies and procedures
Goal: Successfully train 100% of committed clinical staff in use of evidence based protocols.
Data Source: Policies and procedures of care transitions program materials

**Milestone 5:** Estimated incentive payment (Maximum Amount): $1,740,985

**Milestone 6 – [I-1]:** Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies by enrolling 12.5% of the population (750 patients)

**[I-11.1]. Metric:** Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines
Goal: 750 patients
Data Source: Registry or EHR

**Milestone 6:** Estimated incentive payment (Maximum Amount): $1,746,239

**Milestone 8 – [P-2]:** Implement standardized care transition processes

**[P-2.1]. Metric:** Care transitions policies and procedures
Goal: Validate effectiveness of protocols, policies and procedures using 30-day all cause readmission rates derived from administrative data and registry data.
Data Source: Policies and procedures of care transitions program materials

**Milestone 8:** Estimated incentive payment (Maximum Amount): $1,740,985

**Milestone 9 – [I-11]:** Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies by enrolling an additional 25% of target population of patients discharged with a diagnosis of congestive heart failure

**[I-11.1]. Metric:** Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines
Goal: 750 patients
Data Source: Registry or EHR

**Milestone 11:** Estimated incentive payment (Maximum Amount): $1,430,951

**Milestone 12 – [I-11]:** Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies by enrolling an additional 25% of target population of patients discharged with a diagnosis of congestive heart failure

**[I-11.1]. Metric:** Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines
Goal: 750 patients
Data Source: Registry or EHR

Rationale/Evidence: In order to allow for system adoption of care transition processes, it is critical to develop policies and procedures identifying responsible parties, activities, timelines and anticipated outcomes related to a successful discharge and follow-up care.

**Milestone 11:** Estimated incentive payment (Maximum Amount): $1,430,951

**Milestone 12:** Estimated incentive payment (Maximum Amount): $1,430,951

**Milestone 11 – [P-2]:** Implement standardized care transition processes

**[P-2.1]. Metric:** Care transitions policies and procedures
Goal: Validate effectiveness of protocols, policies and procedures using 30-day all cause readmission rates derived from administrative data and registry data.
Data Source: Policies and procedures of care transitions program materials

**Milestone 12:** Estimated incentive payment (Maximum Amount): $1,430,951

**Milestone 11:** Estimated incentive payment (Maximum Amount): $1,430,951

Rationale/Evidence: In order to allow for system adoption of care transition processes, it is critical to develop policies and procedures identifying responsible parties, activities, timelines and anticipated outcomes related to a successful discharge and follow-up care.

**Milestone 12:** Estimated incentive payment (Maximum Amount): $1,430,951

**Milestone 11:** Estimated incentive payment (Maximum Amount): $1,430,951

Rationale/Evidence: In order to allow for system adoption of care transition processes, it is critical to develop policies and procedures identifying responsible parties, activities, timelines and anticipated outcomes related to a successful discharge and follow-up care.
<table>
<thead>
<tr>
<th>Performing Provider: St. Luke’s Episcopal Hospital</th>
<th>127300503.2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 3</td>
<td>2.12.1</td>
</tr>
<tr>
<td>Outcome Measure(s):</td>
<td>A-G</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
</tr>
<tr>
<td>Milestone 2</td>
<td>Milestone 6</td>
</tr>
<tr>
<td>Estimated incentive payment (Maximum Amount): $1,192,718</td>
<td>Estimated incentive payment (Maximum Amount): $1,740,985</td>
</tr>
<tr>
<td>Milestone 3 – [P-7]: Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program</td>
<td>Milestone 7 – [P-9]. Milestone: Implement a case management related registry</td>
</tr>
<tr>
<td>Milestone 4 – [P-9]: Implement a case management related registry to identify target population (estimated at 6000 patients annually)</td>
<td>Milestone 7</td>
</tr>
<tr>
<td>Milestone 5</td>
<td>Milestone 12</td>
</tr>
<tr>
<td>Estimated incentive payment (Maximum Amount): $1,192,718</td>
<td>Estimated incentive payment (Maximum Amount): $1,430,951</td>
</tr>
<tr>
<td>Milestone 6 – [P-9]: Implement a case management related registry</td>
<td>Milestone 10</td>
</tr>
<tr>
<td>[P-9.1]. Metric: Documentation of registry implementation Goal: Register 100% of patients with discharge diagnosis of CHF in registry. Enroll additional 1200 patients in transitional care program. Data source: Registry reports demonstrating case management functionality.</td>
<td>Estimated incentive payment (Maximum Amount): $1,746,239</td>
</tr>
<tr>
<td>Milestone 7 – [P-9]: Implement a case management related registry</td>
<td>Milestone 11</td>
</tr>
<tr>
<td>Estimated incentive payment (Maximum Amount): $1,746,239</td>
<td>Estimated incentive payment (Maximum Amount): $1,746,239</td>
</tr>
<tr>
<td>Milestone 8</td>
<td>Milestone 14</td>
</tr>
<tr>
<td>Estimated incentive payment (Maximum Amount): $1,746,240</td>
<td>Estimated incentive payment (Maximum Amount): $1,746,240</td>
</tr>
</tbody>
</table>

Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions: Transitional Care for Chronic Disease

Potentially Preventable Re-Admissions – 30-day Readmission Rates (PPRs)/Congestive Heart Failure 30-day Readmission Rate

Quality of Life

care according to the approved clinical protocols and care transitions policies by enrolling an additional 25% of target population of patients discharged with a diagnosis of congestive heart failure

**Regional Healthcare Partnership Plan**

Region 3

1468
<table>
<thead>
<tr>
<th>127300503.2.1</th>
<th>2.12.1</th>
<th>A-G</th>
<th>Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions: Transitional Care for Chronic Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing Provider: St. Luke’s Episcopal Hospital</td>
<td>127300503</td>
<td>127300503.3.1</td>
<td>IT-3.2</td>
</tr>
<tr>
<td>Related Category 3</td>
<td>Outcome Measure(s):</td>
<td>IT-10.1</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
</tr>
<tr>
<td>Milestone 4: Estimated incentive payment (Maximum Amount): $1,192,718</td>
<td></td>
<td>Data source: Registry reports demonstrating case management functionality.</td>
<td></td>
</tr>
<tr>
<td>Year 2: Estimated Milestone Bundle Amounts: $4,770,872</td>
<td>Year 3: Estimated Milestone Bundle Amounts: $5,222,954</td>
<td>Year 4: Estimated Milestone Bundle Amounts: $5,238,718</td>
<td>Year 5: Estimated Milestone Bundle Amounts: $4,292,854</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $19,525,398</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
St. Luke's Episcopal Hospital
Pass 2
Project Option 2.2.2 - Apply evidence based care management model to patients identified as having high-risk health care needs

Functionalities: Identification and Treatment of Patients with Hepatitis C
Unique RHP Project ID: 127300503.2.2
Performing Provider Name/TPI: St. Luke’s Episcopal Hospital

Project Summary:

Provider:
St. Luke’s Episcopal Hospital (SLEH) is a 850-bed tertiary and quaternary teaching hospital located in the heart of the Texas Medical Center and is home of the Texas Heart® Institute. Founded in 1954 by the Episcopal Diocese of Texas, St. Luke’s is affiliated with multiple nursing schools and three medical schools.

### Volume Statistics - FY2012 (November annualized)

<table>
<thead>
<tr>
<th></th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital admissions- 28,856</td>
<td>Self-Pay- 4.2% Medicaid and CHIP -4.0%</td>
<td>Caucasian – 48.2%</td>
</tr>
<tr>
<td>Emergency visits (including community emergency centers)- 85,631</td>
<td>Medicare- 47.6% Other Funding -3.2%</td>
<td>African American – 29.8%</td>
</tr>
<tr>
<td>Outpatient visits – 108,224</td>
<td>Commercial Insurance- 41.0%</td>
<td>Hispanic – 14.4%</td>
</tr>
</tbody>
</table>

### Intervention(s):
This project will provide screening and treatment for a defined population of patients at risk for and/or diagnosed with Hepatitis C.

### Need for the project:
Hepatitis C is a potentially curable disease with significant morbidity leading to cirrhosis and liver failure. A small but significant fraction of affected patients develop hepatocellular carcinoma. These complications can be markedly reduced with active screening and aggressive treatment. CDC recommended Birth Cohort Screening of individuals born between 1945 and 1965 will overwhelm capacity without the development of alternate treatment models.

### Target Population:
All patients with liver dysfunction or patients falling within the CDC recommended screening group.

### Category 1 or 2 expected patient benefits:
Our DY4 goal is to triple the volume of patient screened during our baseline year. In DY 5 our goal is to quadruple screening volume over baseline and to enroll at least 50% of patients identified with active disease in treatment.

### Category 3 outcomes:
**Outcome Measure**: OD-4/IT-4.1 Improvement in risk adjusted Potentially Preventable Complication rates (development of cirrhosis, frank liver failure) by 50%.
Category 2 DSRIP Project Narrative

Category: Category 2: Innovation and Redesign

Project Area and Option: Project Area 2.2 – Expand Chronic Care Management Model; Project Option 2.2.2: Apply evidence based care management model to patients identified as having high-risk health care needs

Title of Project: Identification and Treatment of Patients with Hepatitis C

RHP Project Identification Number: 127300503.2.2

Performing Provider Name: St. Luke's Episcopal Hospital

Performing Provider TPI #: 127300503

Project Description: The purpose of this project is to screen, identify, and provide high level care to individuals identified as having Hepatitis C using a distributed care model based on Project ECHO™.

Goals and relationship to regional goals: Hepatitis C is a curable illness when identified and correctly treated. Estimates suggest that only a small fraction of patients with this illness are identified and an even smaller fraction is treated. Since the consequences are progressive cirrhosis, liver failure, and high risk for hepatocellular carcinoma, screening and access to effective treatment can achieve cure in up to 60% of patients. The major barriers are lack of widespread screening and access to providers knowledgeable in this field. By using newer technologies this project will partner with primary care providers throughout Region 3 to support screening, enhance the knowledge base, and support treatment in the patient’s community by extending tertiary specialty support using telemedicine. This project supports Region 3 objectives by improving access to high level specialty care coordinated through primary care providers, leverages technology through use of telemedicine, and supports effective treatment in a vulnerable population where the incidence of disease may be as high as 8%.

Challenges: Effective screening and appropriate referral for care represent the primary hurdles. The CDC recently recommended Birth Cohort Screening for all individuals born between 1945 and 1965 which will significantly increase patients identified with Hepatitis C. Our current system will be unable to manage the volume of new cases in need of active treatment.

5 Year Expected Outcome for Provider and Patient

St. Luke’s expects to increase annual screening of at-risk populations by a factor of 4 by the final year of the project (1976 patients screened in 2012). Of those identified with active disease St.
Luke’s hopes to engage 50% of this group in active community based treatment. Of those with active disease who remain in treatment, cure rates will match recently reported outcome data (60% cure rate).

**Starting Point/Baseline**

In 2012 St. Luke’s Liver Health Outreach Department screened 1976 patients through partnerships with CBO’s and identified 155 individuals with active disease (Hepatitis C).

**Project Valuation**

In Year 2 as partnerships are developed beyond current relationships, 2000 individuals will be screened. In Years 3 and 4 the volume of screening would increase incrementally with the expected volume of screening in Year 4 reaching 8000. As these individuals would be in an at-risk group, the number of individuals identified with disease in Year 2 would be 160, Year 3 - Screened 5000, 400 with disease, Year 4 - 8000 screened, 640 with disease. Total number of individuals identified with disease over project equals 1200. 50% of 1200 new patients will be engaged in active community based treatment with 60% cure rate equaling 360 patients. The lifetime cost of Hepatitis C in the absence of liver transplant is $100,000. With liver transplant, the cost rises to $280,000. Within 5 years of diagnosis, 15-20% of patients with chronic Hepatitis C develop cirrhosis. Consequently, diagnosis, treatment and cure dramatically lower costs for treatment of a chronic disease.

**Milestone and Metrics:**

**The following milestones and metrics have been chosen for this program:**

**Process Milestones:**

P-4.1. Metric: Increase the number of multi-disciplinary teams or number of clinic sites with formalized teams

P-10.1. Metric: Increase the number of group visits and/or telephone visits and/or other interaction types

**Improvement Milestones:**


I-21.2. Metric: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period.
I-11.1 Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies.

I-21.3. Metric: Improved clinical outcomes of target population. The clinical outcomes can be either intermediate (e.g. in Diabetes: HbA1c, lipid profile, blood pressure, serum microalbumin) or end result (e.g. mortality, morbidity, functional status, health status, quality of life or patient satisfaction).

Unique Community Need identification number the project addresses:
- CN1
- CN4
- CN10
- CN12

Related category 3 Outcomes Measures:

Outcome Measure: OD-4/IT-4.1 Improvement in risk adjusted Potentially Preventable Complication rates
Untreated Hepatitis C results in progressive destruction of liver cells with resulting cirrhosis and liver failure. Patients with this disease are at significantly increased risk for the development of hepatocellular carcinoma. Since identification and effective treatment can be curative, a reduction in the rate of Potentially Preventable Complications attests to the effectiveness of the interventions.

Rationale

Provider

St. Luke’s Episcopal Hospital (SLEH) is a 718-bed tertiary and quaternary teaching hospital located in the heart of the Texas Medical Center and is home of the Texas Heart® Institute. Founded in 1954 by the Episcopal Diocese of Texas, St. Luke’s remains the only faith-based hospital within TMC. It is affiliated with multiple nursing schools and three medical schools, University of Texas - Houston, UTMB, and the Baylor College of Medicine. SLEH is the flagship hospital for St. Luke’s Episcopal Health System (SLEHS), comprised of six hospitals, serving all communities within the metropolitan area, and St. Luke’s Episcopal Health Charities, a charity devoted to assessing and enhancing community health, especially among the underserved.

St. Luke’s Center for Liver Disease (SLCLD) is a multidisciplinary program shared between Baylor College of Medicine and St. Luke’s Episcopal Hospital providing hepatology and liver transplantation services. SLCLD includes two transplant surgeons, seven hepatologists and five midlevel providers.

SLCLD houses the St. Luke’s Liver Health Outreach Department, which focuses on identifying, screening and testing patients at high risk for Hepatitis C within the underserved community. In
2012, the department ran 1976 HCV tests resulting in 217 (11%) antibody positive tests and 155 HCV RNA (active infection) positive tests (8%). SLCLD and the department maintain community partnerships with organizations including:

- The Association for the Advancement of Mexican Americans
- Coastal Bend AIDS Foundation (CBAF)
- Legacy Community Health Services
- Planned Parenthood of the Gulf Coast’s HIV program
- Houston Area Community Services (HACS)
- Tomagwa Health Ministries
- Brazos County Health

These partnerships have built a strong foundation for outreach within the greater Houston and Harris County area. Expansion throughout Region 3 will allow SLEH and the SLCLD to reach more high-risk individuals and create a greater health impact to the underserved individual.

Interventions:

Identification and Treatment of Patients with Hepatitis C extends high level medical skills throughout the region using telemedicine to improve care for patients with Hepatitis C. Active identification and aggressive treatment of patients in the early stages of disease result in improved outcomes and lower cost in a population of patients at high risk.

Two factors will alter the impact of HCV infection in Region 3:

1) Patient Identification: Primary care is the front line in screening patients for HCV. Primary care providers must be educated to screen patients with risk factors for HCV, including those born between 1945 and 1965. BCS alone may identify 200,000 new cases in Texas.

2) Access to Treatment: Treatment has traditionally been the domain of the gastroenterologist. This is no longer tenable. Gastroenterologists in large and small communities are hard-pressed to provide all necessary GI support. HCV treatment is increasingly seen as a distraction and money-loser for GI practices. Infectious disease specialists have picked up some of the slack, but the answer is to increase the number of treating practitioners. This effect has been called a “force multiplier,” and is the basis of Project ECHO™, a community outreach program established at the University of New Mexico.

In order to achieve improved identification and treatment of HCV, we will have to increase awareness of HCV infection, and we will have to train a large workforce of providers. The size of Region 3 makes this difficult to do in person (e.g. with outreach clinics), but the problem could be solved with the Project ECHO model described by Arora et al.

Remote sites need only three IT resources: a computer, a webcam and high-speed Internet. Most practices have computers, and many computers have built-in webcams. Training each site to use the webcam and communication software will be done by phone or with Identification and Treatment of Patients with Hepatitis C resources.
Each weekly HCV clinic will consist of two portions, patient presentations and a short lecture — attendees will get two CME units per clinic.

Needs Assessment:

- Primary care physicians are the first line providers in the community, but most do not know the risk factors for hepatitis C.
  - Gap: Patients in the community are not being screened for hepatitis C – only 25% of the HCV infected population in America has been diagnosed. Knowledge about appropriate screening and confirmatory testing is lacking.
  - Desired outcome: Community physicians will screen appropriate patients for HCV infection, confirm infected patients, and recommend treatment, when appropriate.

- Hepatitis C treatment is difficult, inconvenient, and associated with numerous side effects
  - Gap: Gastroenterologists are increasingly unwilling to treat HCV infection, so fewer patients are being treated, even though the efficacy of treatment is improving.
  - Desired outcome: Primary care providers will learn to provide appropriate, specialized treatment in the community.

- Patients with advanced liver disease may require specialized care at a referral center.
  - Gap: Many communities do not have the resources to recognize advanced liver disease and/or implement appropriate measures. In addition, they fail to refer patients to an appropriate center in a timely fashion.
  - Desired outcome: Community physicians learn to recognize cirrhosis, implement appropriate medical measures, and refer patients with advanced liver disease to a referral center.

Target Population:

Based upon the St. Luke’s Liver Center screening experience, we believe that between 4% - 8% of at risk populations are likely infected. If the prevalence reported in a recent Veterans Administration study (4.5%) is applied to the general population of Region 3, as many as 200,000 individuals could be infected. Enormous opportunity exists to significantly alter the disease trajectory of patients with Hepatitis C. Currently available therapies have the potential to cure up to 60% of those patients treated. This project would provide targeted funding to support dramatic expansion of screening programs along with the development of treatment capacity to meet this need. The dual problems of identifying infected patients and getting them treated is the goal of this proposal.
<table>
<thead>
<tr>
<th>127300503.2.2</th>
<th><strong>PROJECT COMPONENT:</strong> 2.12</th>
<th>Identification and Treatment of Patients with Hepatitis C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performing Provider:</strong> St. Luke’s Episcopal Hospital</td>
<td>TPI</td>
<td>127300503</td>
</tr>
<tr>
<td><strong>Related Category 3</strong> <strong>Outcome Measure(s):</strong></td>
<td>IT-4.1</td>
<td>Improvement in risk adjusted Potentially Preventable Complication rates</td>
</tr>
</tbody>
</table>

| Year 2 | Year 3 | Year 4 | Year 5 |

**Milestone 1 - P-4.1.** Metric: Increase the number of multi-disciplinary teams or number of clinic sites with formalized teams

a. Number of teams or sites with formalized teams
b. Data Source: TBD by Performing Provider
c. Rationale/Evidence: In meta-analysis to assess the impact on glycemic control of 11 distinct strategies for quality improvement in adults with type 2 diabetes, team changes and case management showed the most robust improvements.96 Team changes included adding a team member or “shared care,” use of multidisciplinary teams in the primary ongoing

**Milestone 3 - P-10.1.** Metric: Increase the number of group visits and/or telephone visits and/or other interaction types

a. Numerator: Number of group visits/telephone visits/other interaction types (please specify type of visit)
b. Data source: EHR, billing records

**Milestone 3 ; Estimated incentive payment (Maximum Amount):** $286,206

**Milestone 4 - I-21.1.** Metric: Increase percentage of target population reached.

a. Numerator: Number of individuals of target population reached by the

**Milestone 6 - I-11.1.** Metric: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines

a. Numerator: Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines.

**Milestone 8 - I-11.** Milestone: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies

I-11.1. Metric: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines

a. Numerator: Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines.
management of patients, or expansion/revision of professional roles.

**Milestone 1**: Estimated incentive payment (Maximum Amount): $385,040

**Milestone 2**: P-9.1. Metric: Increase the number of patients identified as needing screening test, preventative tests, or other clinical services

a. Numerator: Number of patients identified and subsequently receiving needed tests or other clinical services
b. Denominator: Number of patients identified as needing screening test, preventative tests, or other clinical services

c. Data source: EHR, patient registry

**Milestone 4**: Estimated incentive payment (Maximum Amount): $286,206

**Milestone 5**: I-21.2. Metric: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period.

a. Total number of unique patients encountered in the clinic for reporting period.
b. Data Source: Registry, EHR, claims or other Performing Provider source receiving standardized, evidence-based interventions per approved clinical protocols and guidelines
c. Numerator: Number of patients that receive all recommended preventative tests, or other

**Milestone 6**: Estimated incentive payment (Maximum Amount): $435,537

**Milestone 7**: P-10.1. Metric: Increase the number of group visits and/or telephone visits and/or other interaction types

a. Numerator: Number of group visits/telephone visits/other interaction types (please specify type of visit)
b. Data source: EHR, billing records

**Milestone 8**: Estimated incentive payment (Maximum Amount): $358,518

**Milestone 9**: I-21.2. Metric: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period.

a. Total number of unique patients encountered in the clinic for reporting period.
b. Data Source: Registry, EHR, claims or other Performing Provider source

**Milestone 10**: I-21.3. Metric: Improved clinical outcomes of target population. The clinical outcomes can be either intermediate (e.g. in Diabetes: HbA1c, lipid profile, blood pressure,
education, care and services as dictated by approved and evidence based care guidelines.
d. Denominator: Number of patients discharged or eligible for care transition services
e. Data Source: Registry or EHR report/analysis

**Milestone 5** ; Estimated incentive payment (Maximum Amount): $286,207

**serum microalbumin** or end result (e.g. mortality, morbidity, functional status, health status, quality of life or patient satisfaction).

a. Numerator: Average [clinical outcome] (TBD by provider) of patients participating in Navigator program.
b. Denominator: Average [clinical outcome] (TBD by provider) of all patients.
c. Data Source: EHR
d. Rationale: TBD by provider

**Milestone 10** ; Estimated incentive payment (Maximum Amount): $358,518

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $3,216,809</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $3,216,809</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $3,216,809</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $3,216,809</td>
</tr>
</tbody>
</table>
Texana Center
Pass 1
Project Option 2.13.1 - Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Provide crisis stabilization intervention for the dually diagnosed population to prevent unnecessary use of services in State Supported Living Centers, emergency rooms, state mental hospitals and county jails.

Unique RHP Project Identification Number: 081522701.2.1
Performing Provider Name/TPI: Texana Center / 081522701

Project Description:
This project will create a crisis behavioral health care team to intervene to keep individuals in crisis out of the State Supported Living Centers, emergency rooms, state mental hospitals or jail.

Provider Description:
Texana Center is the Local Authority for Behavioral Healthcare and Intellectual Developmental Disabilities Services for 6 counties within the RHP 3 area: Austin, Colorado, Fort Bend, Matagorda, Waller and Wharton. Texana Center serves approximately 9,800 people annually (an estimated 7,000 in BH services and 3,000 in IDD services), employs 742, and has an annual operating budget of $39,211,988.

Intervention(s):
Design, implement and a research-supported and evidence-based crisis behavioral health care team. Interventions include assessment during acute crisis, treatment plan development by Board Certified Behavior Analyst, monitoring by psychiatrist and nurse, training individuals and care givers in Applied Behavior Analysis, and therapeutic respite. Interventions are to be provided by a clinical team with the purpose to avert institutional care and preserve community living through an innovative crisis behavioral health care team model.

Need for the Project:
As the Local Authority, Texana receives requests to assist families, and providers, dealing with acute crisis for individuals at risk for placement outside of their home. There is no therapeutic respite facility open to all providers in our area, and there is no crisis response team trained in the therapeutic assessment and treatment of the targeted population. There are over 200 active Medicaid providers of long term services and supports for the targeted population in our area. Most are small business operations, and many are new providers with limited resources and experience in the provision of crisis prevention services. Based on current estimates, we expect the project to benefit an estimated 600 individuals over a five year period, serving 150 to 250 individuals annually. Of the 600, potentially 540 individuals will be Medicaid eligible and/or indigent. It is recommended that the project begin with a milestone of 150 individuals in DY 3, increase to 200 in DY 4, and increase to 250 in DY 5.

Target population and Valuation:
The population includes individuals dually diagnosed (intellectual and developmental disability (IDD: i.e., autism, pervasive developmental disorder (PDD) or mental retardation (MR)) who have a co-occurring serious and persistent mental illness and/or a history of challenging and harmful behaviors. This project addresses the need for this population to receive intensive crisis stabilization services in the community. Doing so allows for cost avoidance, supporting individuals in the community at a lesser cost than institutional care in state hospitals and State Supported Living Centers, and avoiding costs in the criminal justice system and emergency rooms. Valuation is based upon UT Houston School of Public Health and the UT Austin Center for Social Work published research studies.

Category 2 expected patient benefits: The project seeks to provide acute crisis behavioral health care services through an innovative crisis team model in years three, four and five with an increase in the number of individuals served by the team and in therapeutic respite each year. The project seeks to promote the evidenced-based model through collaborative learning with other Local Authorities in the RHP area and in the state.

Category 3 Outcomes: The project seeks to reduce the number of potential admissions by the targeted population to state institutions (state mental hospitals and State Supported Living Centers) by 10% in Year 3 and 20% in Year 4.
Project Option 2.13.1 - Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Provide crisis stabilization intervention for the dually diagnosed population to prevent unnecessary use of services in State Supported Living Centers, emergency rooms, state mental hospitals and county jails.

**Unique RHP Project Identification Number:** 081522701.2.1  
**Performing Provider Name/TPI:** Texana Center / 081522701

**Project Description:**

*Texana Center, the local authority for Behavioral Healthcare and Intellectual Developmental Disabilities services, proposes to create a crisis behavioral health care team to intervene to keep individuals in crisis out of the state supported living center, emergency room, state mental hospital or county jail.*

The project will also expand respite care to respond to acute behavior events. It will also provide on-going supports to caregivers to avert crisis and establish stable living environments. The project will require the hiring of 15 staff members (7 professional/clinical and 8 behavioral certified direct care) and the addition of a 4 bed respite facility equipped with 2 clinical treatment rooms.

The project targets individuals with a diagnosis of intellectual and developmental disability (IDD: i.e., autism, pervasive developmental disorder (PDD) or mental retardation (MR)) who have a co-occurring serious and persistent mental illness and/or a history of challenging and harmful behaviors. In collaboration with MHMRA of Harris County, the project is intended to provide crisis stabilization services to the targeted population in all counties of the RHP 3 area. This project serves individuals who reside in one of the following seven counties: Austin, Calhoun, Colorado, Fort Bend, Matagorda, Waller and Wharton. The caregivers for this population are eligible recipients for training and education.

When a behavioral crisis occurs, this complex behavioral health population typically seeks crisis intervention services through the emergency room, psychiatric in-patient system or law enforcement. In these cases, a frequent long term solution is admission to a State Supported Living Center. Individuals with IDD who have a co-occurring SPMI/challenging behavior enter into a cycle of crisis driven care: the individual receives long term supports from a designated in-home caregiver who is unable to manage challenging behaviors; the behaviors result in an acute crisis; the treatment for the crisis is hospitalization or out of home institutional care, which does not involve the caregiver in the treatment plan; the crisis resolves and the individual returns home to the caregiver who still lacks competencies for managing the behaviors; the challenging behaviors reoccur and result in an acute crisis; the cycle repeats, and this complex population becomes a frequent user of local public health systems.

As a solution to the cyclic pattern of long term support and acute crisis intervention for the dually diagnosed IDD/SPMI population, this project proposes the development of a crisis behavioral healthcare team, expanded out-of-home respite care to respond to acute behavior crisis events, and on-going supports to avert crisis and establish stable living environments. The crisis behavioral health care team will respond to acute crisis and will design, implement, and monitor individualized treatment plans for individuals admitted to the project.
Goals and Relationship to Regional Goals:
The project supports the RHP 3 regional goal for developing a culture of ongoing transformation and innovation that maximized the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes. This project also supports regional goals to address the gaps in the service delivery system for individuals with complex mental health conditions. These individual require stable living environment integrated with community-based clinical psychosocial services to prevent continual cycling through less appropriate, more costly settings.

5-Year Expected Outcomes for Provider and Patients:
- A significant decrease in the number of behavioral health events resulting in hospitalization, incarceration or institutional care for individuals with IDD
- A significant increase in the number of individuals with IDD who have access to behavior supports provided by Board Certified Behavior Analyst and who have access to emergency respite

Starting Point/Baseline:
The NADD, an association for persons with developmental disabilities and mental health needs, reports that many professionals have adopted the estimate that 30-35% of all persons with an intellectual developmental disability have a psychiatric disorder.1 By applying the NADD estimated percentage (30-35%) to the intellectual and developmental disabilities population in our area (3,650: 1,250 served; 2,400 not served), it is estimated that the baseline population is 1,100-1,300 people with potential needs for the crisis stabilization services proposed in this project. This number is consistent with state data source (CARE), which reported 1,427 individuals with IDD and a co-occurring SPMI or diagnosis of autism or PDD being screened, assessed or served through Texana Center in 2011. Based on provider service data for 2011, it is estimated that about 50% of the baseline population received some type of crisis stabilization encounter (i.e., intensive behavior supports and/or emergency respite), meaning that there were approximately 600 under-served individuals. Approximately 90% of the persons served are currently Medicaid eligible and/or indigent. Based on these estimates, we expect the project to benefit an estimated 600 individuals over a five year period, serving 150 to 250 individuals annually. Of the 600, potentially 540 individuals will be Medicaid eligible and/or indigent. It is recommended that the project begin with a milestone of 150 individuals in DY 3, increase to 200 in DY 4, and increase to 250 in DY 5.

There are over 200 active Medicaid providers of long term services and supports for the targeted population in our area, but there is no crisis response team and no therapeutic crisis respite facility. Most providers are small business operations, and many are new providers with limited resources and experience in the provision of crisis prevention and services.

Rationale:
The implementation of a long-term crisis intervention and stabilization services model is intended to promote health and safety, to promote self-management of challenging behaviors, and to avoid risks requiring hospitalization, incarceration or institutionalization. Texana Center selected this project for the following reasons:

---

1 Source: NADD website: [http://thenadd.org/resources/information-on-dual-diagnosis/](http://thenadd.org/resources/information-on-dual-diagnosis/)
• Data driven: As noted in the baseline above, local data demonstrates that there is a growing number of individuals with IDD with challenging behaviors and/or SPMI, who are seeking respite and behavioral supports in the community.

• Community Need: This project addresses the community need for expanded behavioral healthcare: RHP CN 2 - Insufficient access to behavioral health care services, resulting in lack of care or delay of care, delivery of inappropriate and insufficient care, unnecessary and preventable complications, and increased demand on criminal justice system.

• Cost effective: This project’s goal is to avert the cost of long term crisis intervention through provision of in-home and community setting care. The following cost savings were considered in the selection of this project: average annual cost for State Supported Living Center of $177,624 compared to average annual cost rate the Home and Community Based Care (HCS) Waiver of $39,588; the average stay cost for psychiatric in-patient care at a State Mental Hospital of $15,325 compared to the annual per person Behavioral health community center cost of $1,181; the average cost of an emergency room visit of $383 compared to primary care visit cost of $60; and the annual cost for incarceration rate at State prison of $18,582 compared to the non incarceration cost of zero. The intent of this project is to ensure that patients utilize the most cost efficient service identified by these comparisons.

• State and Federal Initiatives: This project, through the implementation of behavioral support teams and access to respite for individuals in crisis, represents a significant enhancement to the long-term care IDD services and supports system and is consistent with current State and Federal initiatives.
  o In 2009, the Community Living Initiative was implemented by the U.S. Department of Health and Human Services (HHS). Through this initiative, HHS partnered with State and Local authorities to develop strategies to create infrastructure to effectively serve individuals with IDD. This work helped advance systems of care to meet the directive of the 1999 Olmstead decision.
  o North Carolina implemented the NC START (North Carolina Systemic, Therapeutic Assessment, Respite and Treatment) Program as a partner in the Community Living Initiative, which, like this project, provided clinical behavior support teams and out of home respite to the IDD with SPMI/challenging behavior population.
  o In 2011, the Texas Legislature directed the Texas Health and Human Services Commission to seek a Medicaid waiver that “allow[s] for the redesign of [IDD] long-term care services and supports to increase access to patient-centered care in the most

---

2 Source: Legislative Budget Board Report: Fiscal Size Up 2012-2013
3 Source: Legislative Budget Board Report: Managing and Funding State Mental Hospitals in Texas, February 2011
4 Source: Blue Cross Blue Shield website: http://www.bcbstx.com/employer/cost/er.htm
A key feature for the redesigned system for individuals with IDD is behavioral supports for individuals at risk of institutionalization.

- There is an on-going agreement settlement between the Texas and the Department of Justice for ensuring access to community services for persons served in institutions. Access to crisis intervention and stabilization services in the community is an expectation of the Department of Justice through this agreement. This project, through the implementation of behavioral support teams and access to respite for individuals in crisis, represents a significant enhancement to the long-term care IDD services and supports system to provide the right service at the right time in a most cost-effective manner.

- Regional Pilot: MHMRA of Harris County implemented a behavioral healthcare crisis intervention team for this targeted IDD population in 2011. The model has been well received at the local and state level.

- Experience: As a starting point, Texana Center has the administrative support and clinical expertise to assess and develop a plan for a long term crisis intervention and stabilization model for this targeted population:
  - Out of home emergency respite: Texana Center has operated an out of home respite facility for over 20 years.
  - Applied Behavior Analysis: Texana Center employs Board Certified Behavior Analyst to assess, treat and monitor challenging programs in four program areas: day program, residential, site-based and outreach. These programs have an excellent reputation for successful treatment of challenging behaviors.

Consistent with the DSRIP Category 2 Behavioral Health Infrastructure menu, this project incorporates the required core components for Project Option 2.13.1: Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population (IDD with SPMI/Challenging behaviors).

- An assessment of size, characteristics and needs of the IDD with SPMI/Challenging behavior population.
- A review literature/experience with populations similar to the IDD with SPMI/Challenging behavior population.
- A project evaluation plan using qualitative and quantitative metrics to determine outcomes.
- A service delivery model to include the following community based interventions:
  - Referral paths for IDD Crisis Stabilization team through outreach and education with law enforcement, emergency rooms, and agencies providing residential supports to persons with IDD.
  - Behavioral healthcare intervention team consisting of project director, Board Certified Behavior Analysts, case coordinators and registered nurse to assess individuals in crisis, develop treatment plans and monitor care.
  - Visiting nursing and community health workers with crisis intervention expertise
  - Specialized behavioral therapies:
    - On-site assessments and interventions to stabilize acute crisis situations

---

8 Source: Texas Department of Aging and Disability Services website: http://www.justice.gov/crt/about/spl/documents/TexasStateSchools_settle_06-26-09.pdf
Individualized treatment plans to help the individual return to his/her current living situation, and to successfully maintain that setting.

Intensive training in Applied Behavior Analysis (ABA) techniques to individuals, family members and caregivers:
- Medication assessment with weekly psychiatric consultation.
- Out of home respite for crisis stabilization and based on population needs.
- Other community based interventions as determined by the project assessment.

- An assessment of the impact of the interventions based on standardized quantitative measures and qualitative analysis.

- A continuous quality improvement framework to include collaborative learning with other providers for the IDD with SPMI/Challenging behavior population.

**Milestones & Metrics:**
Milestones 2.13.1 (Assessment), 2.13.2 (Designing/Planning), 2.13.3 (Enrolling/Serving), 2.13.5 (Collaborative Learning) were selected to support the above listed required components. As an improvement measure, assessment of improvement in functional status was selected for Category 2. See section to follow regarding related Category 3 Outcome Measures.

**Related Category 3 Outcome Measures:**
IT-9.4 Other Outcome Improvement Target- Mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers)

This project supports and reinforces Quality Improvement projects in Category III related to potentially preventable admissions and readmissions for behavioral health populations. Contingent upon the baseline assessment completed in DSRIP Year 2, the following related Category 3 Outcome Measures, Outcome Domain 9 – Right Care, Right Setting, may apply:

- Decrease in mental health (by targeted population -IDD with co-occurring SPMI or Challenging Behaviors) admissions and readmissions to criminal justice settings such as jails or prisons
- Decrease in Emergency Department visits for target population (IDD with co-occurring SPMI or Challenging Behaviors)
- Decrease in admissions and readmissions to skilled Intermediate Care Facilities (ICF/ID)-State Supported Living Centers

This project’s goal is to avert the cost of long term crisis intervention through provision of in-home and community setting care. Consistent with the project’s goal for continuous quality improvement, Category 3 includes a Process for Plan, Do, Study, Act (PDSA). Admissions and readmissions to criminal justice settings and to long term care settings can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning. See Rationale section above for supporting data.

**Relationship to other Projects:** The development and improvement of services for patients with behavioral health disorders is a focus of multiple projects throughout the RHP, including those in Category I for expanding access and Category II for developing innovative solutions to priority issues. This project supports areas focusing on the expansion and development of medical home models, expansion and development of preventive and urgent care, and improvement in the quality of life for patients.

**Relationship to Other Performing Providers Projects in the RHP:**
Numerous community needs assessments reflect an extreme need for behavioral health services to include outpatient treatment centers, crisis stabilization units, inpatient beds, and much more. The lack of funding as well as complexity of the region’s patient base has limited the amount of behavioral health treatments available to our region and continues to drive cost in emergent and inpatient situations. The Crisis Stabilization Unit has a direct correlation to all behavioral health programs recommended in the RHP plan and will be a focus of two of the largest Local Mental Health Authorities of our region. Both CSU's share the outcome measures of mental health admissions & readmissions, and improvement of patient satisfaction scores. The Region 3 Initiative Grid attached in the addendum reflects the direct relationships of this initiative.

Local Authorities for IDD (Intellectual Developmental Disabilities) are a large focus of our community including our local mental health authorities in the region. The IDD concepts focus to outcome measures of patient satisfaction scores, and admission/re-admission rates. There are two initiatives in the RHP plan with a focus to IDD and are represented in the addendum (Region 3 Initiative Grid).

**Plan for Learning Collaborative:**

Texana Center and MHMRA of Harris County share a network of providers for Medicaid services (Home and Community Based Services Waiver, Texas Home Living Program, and ICF/ID programs), and collaborate to meet monthly with the providers for an exchange of information. Through this project, Texana Center and MHMRA of Harris County will expand this collaboration to include monthly telephone conferences to share best practices, new ideas and solutions for the crisis stabilization projects. The established provider meetings will provide an effective forum for gathering input of stakeholders in the projects processes. Additionally, both Texana Center and MHMRA of Harris County meet with representatives of Local Authorities statewide on a quarterly basis, and will request that these meetings include information sharing about similar projects in other areas of the state.

Through this expanded learning collaborative, Texana Center and participating Local Authorities will share challenges, testing of new ideas and solutions. Additionally, Texana Center plans to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system. This exchange will facilitate effective processes, efficient use of resources, and consistent data benchmarking across similar projects statewide.

**Project Valuation:** This project addresses a priority need for the IDD/SPMI population to receive intensive crisis stabilization services in the community. By doing so, it also allows for cost avoidance, supporting individuals in the community at a lesser cost than institutional care in state hospitals and State Supported Living Centers, and avoiding costs in the criminal justice system and emergency rooms. This project was valued based on two studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research: “Valuing the Program to Create an Assertive Community Treatment (ACT) Team for People with Intellectual and Developmental Disabilities (IDD)” and “Valuing the Crisis Respite for Children Program”. These studies were completed through a contract with Center for Health Care Services, and were based on cost-utility analysis measures and quality-adjusted life-years analysis.

**Total Five Year Valuation: $5,574,005**
Crisis stabilization service model for individuals with intellectual development disability and serious persistent mental illness and/or challenging behaviors to prevent unnecessary use of services in specified setting

**Texana Center**

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Other Outcome Improvement Target: Mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>081522701.2.1</td>
<td>2.13.1</td>
<td>081522701.3.3</td>
</tr>
<tr>
<td></td>
<td>2.13.1.A-E</td>
<td>IT 9.4</td>
</tr>
</tbody>
</table>

**Year 2** (10/1/2012 – 9/30/2013)

**Milestone 1** [P-1]: Conduct needs assessment of the IDD/SPMI population, a complex behavioral health population, who are frequent users of community public health resources.

**Metric 1** [P-1.1]: Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization.

- Data Source: Project documentation; Inpatient, discharge and ED records; State psychiatric facility records; survey of stakeholders (inpatient providers, mental health providers, social services, and forensics); literature review.

Milestone 1 Estimated Incentive Payment (maximum amount): $936,503.50

**Milestone 2** [P-2]: Design community-based specialized interventions for target population (IDD with SPMI/Challenging MSLC).

**Milestone 3** [P-3]: Enroll and serve individuals with targeted complex needs (IDD/SPMI population with concomitant circumstances such as forensic involvement, emergency departments, psychiatric and institutional facilities).

**Metric 1** [P-3.1]: Number of targeted individuals enrolled/served in the project.

- Baseline/Goal: Baseline to be determined in Year 2 assessment/Goal of 150 enrolled/served.
- Data Source: Project documentation.

Milestone 3 Estimated Incentive Payment: $571,727.50

**Milestone 4** [P-5]: Participate in at least biweekly interactions (meetings, conference calls, or webinars) with other providers, and the RHP to promote collaborative learning around shared or similar projects.

Participation includes: 1) sharing challenges and any solutions; 2) sharing results and quantitative progress on new improvement that the

**Milestone 5** [P-3]: Enroll and serve individuals with targeted complex needs (IDD/SPMI population with concomitant circumstances such as forensic involvement, emergency departments, psychiatric and institutional facilities).

**Metric 1** [P-3.1]: Number of targeted individuals enrolled/served in the project.

- Baseline/Goal: Baseline to be determined in Year 2 assessment/Goal of 200 enrolled/served.
- Data Source: Project documentation.

Milestone 5 Estimated Incentive Payment: $434,029.66

**Milestone 6** [P-5]: Participate in at least biweekly interactions (meetings, conference calls, or webinars) with other providers, and the RHP to promote collaborative learning around shared or similar projects.

Participation includes: 1) sharing challenges and any solutions; 2) sharing results and quantitative progress on new improvement that the

**Milestone 7** [P-3]: Enroll and serve individuals with targeted complex needs (IDD/SPMI population with concomitant circumstances such as forensic involvement, emergency departments, psychiatric and institutional facilities).

**Metric 1** [P-3.1]: Number of targeted individuals enrolled/served in the project.

- Baseline/Goal: Baseline to be determined in Year 2 assessment/Goal of 200 enrolled/served.
- Data Source: Project documentation.

Milestone 7 Estimated Incentive Payment: $418,029.66

**Milestone 8** [P-5]: Participate in at least biweekly interactions (meetings, conference calls, or webinars) with other providers, and the RHP to promote collaborative learning around shared or similar projects.

Participation includes: 1) sharing challenges and any solutions; 2) sharing results and quantitative progress on new improvement that the

**Milestone 9** [P-5]: Participate in at least biweekly interactions (meetings, conference calls, or webinars) with other providers, and the RHP to promote collaborative learning around shared or similar projects.

Participation includes: 1) sharing challenges and any solutions; 2) sharing results and quantitative progress on new improvement that the

Regional Healthcare Partnership Plan

Region 3

1488
| 081522701.2.1 | 2.13.1 | 2.13.1.1-e | Crisis Stabilization Service Model for Individuals with Intellectual Developmental Disability and Serious Persistent Mental Illness and/or Challenging Behaviors to Prevent Unnecessary Use of Services in Specified Setting |
| Texana Center | 081522701 |
| Related Category 3 Outcome Measure(s): | 081522701.3.3 | IT 9.4 | Other Outcome Improvement Target: Mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers) |

| Year 2 | Year 3 | Year 4 | Year 5 |
| Behaviors). Interventions will include specialized behavioral therapies (Applied Behavior Analysis), Respite care (short term); Visiting Nursing and/or community health worker services. | Metric 1 [P-2]: Project plans which are based on evidence/experience and which address the project goals. Data Source: Project documentation Milestone 2 Estimated Incentive Payment: $936,503.50 | Metric 1 [P-5.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-5.2]: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary. Milestone 4 Estimated Incentive Payment: $571,727.5 | Metric 1 [P-5.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-5.2]: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary. Milestone 6 Estimated Incentive Payment: $434,329.66 |

Metric 1 [P-2]: Project plans which are based on evidence/experience and which address the project goals. Data Source: Project documentation Milestone 2 Estimated Incentive Payment: $936,503.50

Metric 1 [P-5.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-5.2]: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary. Milestone 4 Estimated Incentive Payment: $571,727.5

Metric 1 [P-5.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-5.2]: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary. Milestone 6 Estimated Incentive Payment: $434,329.66

Metric 1 [P-5.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-5.2]: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary. Milestone 9 Estimated Incentive Payment: $418,184.66
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Other Outcome Improvement Target- Mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>081522701.3.3</td>
<td>IT 9.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Milestone 7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Milestone 10</td>
</tr>
</tbody>
</table>
### Crisis Stabilization Service Model for Individuals with Intellectual Developmental Disability and Serious Persistent Mental Illness and/or Challenging Behaviors to Prevent Unnecessary Use of Services in Specified Setting

**Texana Center**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>081522701.3.3</th>
<th>IT 9.4</th>
<th>Other Outcome Improvement Target - Mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $1,873,007</td>
<td>Year 3 Estimated Milestone Bundle Amount: $1,143,455</td>
<td>Year 4 Estimated Milestone Bundle Amount: $1,302,989</td>
<td>Year 5 Estimated Milestone Bundle Amount: $1,254,554</td>
</tr>
</tbody>
</table>

**Payment**:
- Year 2: $434,329.66
- Year 3: $418,184.66
- Year 4: $1,302,989
- Year 5: $1,254,554

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over DYs 2-5): $5,574,005
Texas Children's Hospital
Pass 1
**Project Option 2.1.4 “Other” project option: Expand Medical Homes for Transition Population**

**Unique RHP Project ID:** 139135109.2.1

**Performing Provider Name/TPI:** Texas Children’s Hospital/ 139135109

**Project Summary:**
Expand a medical home to serve additional adolescent/ young adults with significant chronic childhood conditions.

**Provider:**
Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric and women’s patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatritian group and two world class hospitals.

<table>
<thead>
<tr>
<th>Volume Statistics - FY2012</th>
<th>Patient Payor Mix</th>
<th>Patient Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765</td>
<td>Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%</td>
<td>Hispanic- African American- Caucasian- Asian- Other- American Indian-</td>
</tr>
</tbody>
</table>

**Intervention(s):**
The project will offer a medical home to adolescent/young adults with significant chronic childhood conditions. The clinic will not only offer health care and prevention services but also proactive care coordination and case management to a very vulnerable population of patients. The clinic will emphasis quality of care, increase patient satisfaction and address patient safety by preventing emergency room visits and acute hospital stays.

**Need for the project:**
The majority of adolescent/young adults with chronic childhood conditions have difficulty engaging in adult health care services as they age out of the pediatric health care system because of numerous barriers they face such as adult health care providers who haven't been trained to care for pediatric conditions, unfunded or poorly funded insurance and time consuming care. Many of these patients end of using the emergency room for episodic care.

**Target Population:**
All adolescent/young adults, age 17 and up who have a life threatening chronic childhood condition in Harris County could benefit from having a medical home with adult health care providers who are dedicated to caring for this vulnerable population of patients.

**Category 1 or 2 expected patient benefits:**
Our DY 3 goal is to increase patient visits by 20% from the baseline in fiscal year 2012 or 480 patients.
DY4 goal is to increase patient visits by 30% from the baseline in fiscal year 2012 or 520 patients. DY 5 goal is to increase patient visits by 40% from the baseline in fiscal year 2012 or 560 patients.

**Category 3 outcomes:**
OD 6 Patient Satisfaction
IT-6.1(2) Physician call back, improvement percentage
Project Option-2.1.4 “Other” project option: Expand Medical Homes for Transition Population

**Unique Project ID:** 139135109.2.1  
**Performing Provider and TPI:** Texas Children’s Hospital/139135109

**Project Description:**
*Texas Children’s Health will establish a patient centered medical home for medically fragile children in order to provide proactive care coordination, chronic disease management, and a multi-disciplinary approach that educates patients and providers on appropriate transition processes.*

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the country specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Due to recent advancements in health care, over 90% of children with special health care needs now live into adulthood.\(^1\) Over 11.2 million children with special health care needs, including those with chronic illnesses and disabilities, live in the United States, and, nationally, only 40% successfully transition from the pediatric to the adult health care setting.\(^2\) Texas accounts for 9% of this total with over 1 million children with special health care needs, and, of this population, only 35% successfully transition into the adult health care environment. Across the country, approximately 500,000 adolescents and young adults with chronic, pediatric-onset diseases such as spina bifida, Down syndrome, cerebral palsy, congenital heart disease, autism, and numerous genetic disorders will reach the age of necessary transition this year (18-21 years of age).\(^3\) Patients who do not transition to appropriate adult providers end up seeking care at Texas Children’s emergency room. For children and adults, especially those with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home. This project will expand a Meds/Peds primary care approach for this patient population and establish a patient centered medical home for the population in order to provide proactive care coordination, chronic disease management, and a multi-disciplinary approach that educates patients and providers on appropriate transition processes.

---


Specifically, this population will be impacted directly by the overall coordination of care. Chronically ill children transitioning into adulthood lose access to critical subspecialty care due to lack of providers trained in the appropriate specialties, lack of adult special needs insurance coverage options and limited primary care solutions.

The value of this project can be measured with access, population management and overall quality of life.

Access metrics would include a reduction in clinic next available to within 14 days,

A focus to population management will reduce emergency room use by 25%; average length of stay by nearly one day and improve the quality of life as measured by activities of daily living.

**Goals and Relationship to Regional Goals:**

**Project Goals:** To meet the growing demand for medical home services TCH will:

1. Improve data exchange between hospitals and affiliated medical home sites
2. Develop best practices plan to eliminate gaps in the readiness assessment
3. Hire and train team members to create multidisciplinary teams including social workers, patient navigators, care managers, and nurses with a diverse skill set that can meet the needs of the shared, high-risk patients
4. Implement a comprehensive, multidisciplinary intervention to address the needs of the shared, high-risk patients
5. Evaluate the success of the intervention at decreasing ED and inpatient hospitalization by shared, high-risk patients and use this data in rapid-cycle improvement to improve the intervention.

**NOTE:** this initiative will dramatically impact the lives of 100% of the special needs population projected to be over 10,000 in greater Houston. The care coordination services include: medical, surgical, inpatient, outpatient, social economic, job placement, insurance counseling coverage, case management, social worker, educational training and engagement of local and national advocacy groups.

This project meets the following Region 3 Goals:

- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly
- Insufficient access to care coordination practice management and integrated care treatment programs
Increased access to appropriate care leads to better long term outcomes in children and reduction in unnecessary health care costs.\textsuperscript{4}

\textbf{Challenges:}
In Texas, limited Medicaid reimbursement is an ongoing challenge for children’s hospitals and the workforce that provides health care services for the pediatric population enrolled in this program and even more so for this patient population as they are moved over into the adult Medicaid system of care. As advocates for improving and sustaining quality children’s health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded. In addition to the inadequate reimbursement model for Medicaid, another challenge with this population of patients is adult health care providers are not familiar with chronic childhood conditions such as Down syndrome and spina bifida as they are not adequately trained as medical students and residents on how to provide care for them. A large percentage of these patients are underinsured (Medicaid) and require labor intensive and time consuming care.

By having this clinic in an academic setting we are addressing provider readiness by training adult health care providers such as internal medicine residents and family residents and in addition exposing medical students and other allied health care providers to this patient population. Efforts to add transition healthcare to medical student and resident curriculum are ongoing and in the future, CME (continuing medical education) opportunities for practicing physicians are being planned. We are also recruiting Med-Peds residents into the practice of transition medicine as they are uniquely qualified to care for this population of patients. Because of the possible opportunity to care for this population of patients, interest from Med-Peds physicians is growing to championing this effort. Another barrier is family readiness. Many of patients and their families will have significant health care issues superimposed on a developing child resulting in health care needs that are constantly changing in the pediatric health care system. This leaves no time for health care providers and their patients to start the transition process as they age out of the pediatric health care system.

\textbf{Five year expected outcome for provider and patients:}
Texas Children’s Hospital expects to see improvements in coordination of care provided to the individuals enrolled in the patient centered medical home. We expect this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

\textbf{Starting Point/Baseline:} The transition clinic will increase the number of patients seen from 400 to 480 in DY 3, 520 in DY4 and 560 in DY 5.

\textbf{Rationale:}
Inadequate access to primary and specialty care has contributed to the limited scope and size of safety net health systems. This project will establish a “home base” for patients, where patients

have a health care team that is tailored to the patient’s health care needs, coordinates the patient’s care, and proactively provides preventive, primary, routine and chronic care, so that patients may see their health improve, rely less on costly emergency department (ED) visits, incur fewer avoidable hospital stays, and report a greater patient experience of care. Since the targeted population includes adolescents and young adults with chronic and/or special health care needs, staff will focus great energy in appropriate care coordination and disease management in order to eliminate the historical drop of care for this patient group.

Furthermore, proactive care coordination across multiple sub-specialties, along with access to medical home physicians and staff, will reduce the number of unnecessary EC visits and hospital admissions while simultaneously reducing the associated costs. Additionally, this project will enhance the patient experience by providing care in an appropriate setting for the patient's age and educating the patient and/or family as they transition into the role of primary health care decision maker. For adolescents with health care needs that exceed the abilities of the primary care provider, access to and coordination of specialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home. Increasing pediatric population living into adulthood with chronic pediatric diseases is driving the need for increased access. Our project significantly enhances the existing transition services available to this growing population.

**Project Components:** Through the expanded access to the transition medicine medical home, we propose to meet all required project components listed. These selected milestones and metrics do relate to project components.

a. Expand Transition Medicine Medical Home Services
b. Implement transparent standardized referrals across the system
c. Increase service availability hours

**Milestones and Metrics**
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P14, P-21 (P-21.1)
  - The project requires a customizable metric in order to ensure accountability of the implementation of such an at-risk fragile community.
  - The milestone and metrics require personal interaction with these families to best understand the specific needs
  - Recruitment of providers with this subspecialty is difficult considering the national demand and competition
- Improvement milestones and metrics: I-15 (I-15.1)

**Unique community need identification numbers the project addresses:**
- CN. 2 Inadequate access to specialty care
- CN. 6 Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
Currently the Baylor Transition Medicine Clinic is only one of a handful of clinics in the United States that is specifically serving adolescent/young adults with significant childhood conditions as they move out of the pediatric into the adult healthcare system. This project will allow the clinic to significantly expand the scope of services across the city of Houston and Harris County so that this patient population will have a seamless transition into accessible healthcare that is coordinated, comprehensive and compassionate.

**Related Category 3 Outcome Measure(s):**
OD-6 Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores

**Reasons/rationale for selecting the outcome measures:**
Our project will increase appropriate access to patient centered coordinated care. Increased access to appropriate care leads to better long term outcomes in children and reduction in unnecessary health care costs. This population will still need to be hospitalized but we believe that through appropriate access and care coordination we will be able to reduce the cost of care.

**Relationship to other Projects:** All of Texas Children’s projects are working to expand appropriate access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers. This project will help those patients who grow up at Texas Children’s to transition to appropriate adult providers.

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

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

**Project Valuation:** This project’s value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation also

---

includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.

---

### Regional Healthcare Partnership Plan

**1501**

**Region 3**

Each participating provider can do to “raise the floor” for improvements (simple initiatives that all providers should identify and agree upon several improvements around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating

<table>
<thead>
<tr>
<th>Related Category</th>
<th>Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-X]</td>
<td>Expand the medical home centered on patients transitioning out of pediatric care and into adult care who have chronic pediatric conditions.</td>
<td><strong>Milestone 3</strong> [I-15]: Increase the number or percent of medical home patients that are able to identify their usual source of care as being managed in medical homes.</td>
<td><strong>Milestone 5</strong> [I-15]: Increase the number or percent of medical home patients that are able to identify their usual source of care as being managed in medical homes.</td>
<td><strong>Milestone 7</strong> [I-15]: Increase the number or percent of medical home patients that are able to identify their usual source of care as being managed in medical homes.</td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-X]: Hire one additional provider.</td>
<td>Baseline/Goal: Add one provider and support staff to the current .8 provider team in order to meet the most immediate needs of the growing patient population.</td>
<td><strong>Metric 1</strong> [I-15.1]: Usual source of care a. Numerator: Number of medical home patients that are able to identify their medical home as their usual source of care. b. Denominator: Total number of patients enrolled in the medical home.</td>
<td><strong>Metric 1</strong> [I-15.1]: Usual source of care a. Numerator: Number of medical home patients that are able to identify their medical home as their usual source of care. b. Denominator: Total number of medical home patients.</td>
<td><strong>Metric 1</strong> [I-15.1]: Usual source of care a. Numerator: Number of medical home patients that are able to identify their medical home as their usual source of care. b. Denominator: Total number of medical home patients.</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> HR Documentation</td>
<td><strong>Goal:</strong> Increase patient volumes by 20% or 480 patients.</td>
<td><strong>Goal:</strong> Increase patient volumes by 30% or 520 patients.</td>
<td><strong>Goal:</strong> Increase patient volumes by 40% or 560 patients.</td>
<td><strong>Goal:</strong> Increase patient volumes by 40% or 560 patients.</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-14]</td>
<td>Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating</td>
<td><strong>Milestone 4</strong> [P-14]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance).</td>
<td><strong>Milestone 6</strong> [P-14]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance).</td>
<td><strong>Milestone 8</strong> [P-14]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Texas Children’s Hospital</strong></th>
<th><strong>139135109</strong></th>
<th><strong>Related Category 3</strong></th>
<th><strong>139135109.3.43</strong></th>
<th><strong>IT- 6.1(2)</strong></th>
<th><strong>Percent improvement over baseline of patient satisfaction scores</strong></th>
<th><strong>139135109</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 3</strong> Estimated Incentive Payment: $749,773</td>
<td><strong>Milestone 5</strong> Estimated Incentive Payment: $820,339.50</td>
<td><strong>Payment:</strong> $749,773</td>
<td><strong>Payment:</strong> $817,962</td>
<td><strong>Payment:</strong> $820,339.50</td>
<td><strong>Payment:</strong> $677,672</td>
<td><strong>Payment:</strong> $767,672</td>
</tr>
<tr>
<td><strong>Milestone 4</strong> Estimated Incentive Payment: $817,962</td>
<td><strong>Milestone 6</strong> Estimated Incentive Payment: $820,339.50</td>
<td><strong>Metric 1</strong> Estimated Incentive Payment: $817,962</td>
<td><strong>Metric 1</strong> Estimated Incentive Payment: $820,339.50</td>
<td><strong>Metric 1</strong> Estimated Incentive Payment: $677,672</td>
<td><strong>Metric 1</strong> Estimated Incentive Payment: $767,672</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Number</strong></th>
<th><strong>Denominator</strong></th>
<th><strong>N/A</strong></th>
<th><strong>“OTHER” PROJECT OPTION: EXPAND MEDICAL HOMES FOR TRANSITION POPULATION</strong></th>
<th><strong>N/A</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>139135109.2.1</td>
<td>2.1.4</td>
<td>N/A</td>
<td><strong>Texas Children’s Hospital</strong></td>
<td>139135109</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Data Source:</strong> HR Documentation</th>
<th><strong>Outcome Measure(s):</strong></th>
<th><strong>Baseline/Goal:</strong></th>
<th><strong>Metric 1</strong></th>
<th><strong>Goal:</strong></th>
<th><strong>Goal:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IT- 6.1(2)</strong></td>
<td><strong>Patient satisfaction scores</strong></td>
<td><strong>Increase the number or percent of medical home patients that are able to identify their usual source of care as being managed in medical homes.</strong></td>
<td><strong>Usual source of care a. Numerator:</strong> Number of medical home patients that are able to identify their medical home as their usual source of care. <strong>Goal:</strong> Increase patient volumes by 20% or 480 patients.</td>
<td><strong>Usual source of care a. Numerator:</strong> Number of medical home patients that are able to identify their medical home as their usual source of care. <strong>Goal:</strong> Increase patient volumes by 30% or 520 patients.</td>
<td><strong>Usual source of care a. Numerator:</strong> Number of medical home patients that are able to identify their medical home as their usual source of care. <strong>Goal:</strong> Increase patient volumes by 40% or 560 patients.</td>
</tr>
<tr>
<td>Related Category 3</td>
<td>Outcome Measure(s):</td>
<td>Related Category 3</td>
<td>Outcome Measure(s):</td>
<td>Related Category 3</td>
<td>Outcome Measure(s):</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------------</td>
<td>-------------------</td>
<td>----------------------</td>
<td>-------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>139135109.2.1</td>
<td>2.1.4</td>
<td>N/A</td>
<td>“OTHER” PROJECT OPTION: EXPAND MEDICAL HOMES FOR TRANSITION POPULATION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Children’s Hospital</td>
<td></td>
<td>139135109</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Outcome Measure(s):**

- IT- 6.1(2) Percent improvement over baseline of patient satisfaction scores

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>provider should publicly commit to implementing these improvements.</td>
<td>provider should publicly commit to implementing these improvements.</td>
<td>several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
<td>(simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.</td>
</tr>
<tr>
<td>Metric 1 [P-14.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</td>
<td>Metric 1 [P-14.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</td>
<td>Metric 1 [P-14.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</td>
<td>Metric 1 [P-14.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</td>
</tr>
<tr>
<td>Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $749,773</td>
<td>Milestone 4 Estimated Incentive Payment: $817,962</td>
<td>Milestone 6 Estimated Incentive Payment: $820,339.50</td>
<td>Milestone 8 Estimated Incentive Payment: $677,672</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone):** $1,499,546

**Year 3 Estimated Milestone Bundle Amount: $1,635,924**

**Year 4 Estimated Milestone Bundle Amount: $1,640,679**

**Year 5 Estimated Milestone Bundle Amount: $1,355,344**

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $6,131,493
The Methodist Hospital
Pass 1
Project Option 2.17.1 - Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Implement Care Transition Coordination

Unique Project ID#: 137949705.2.1
Performing Provider Name / TPI: The Methodist Hospital / 137949705

Project Summary:

Provider: Methodist is a delivery system comprised of 4 community hospitals, 1 academic medical center in the Texas Medical Center, research institute, physician organization which employs 350 physicians and operates multiple ancillary care sites throughout the Houston metropolitan area. Methodist has 13,867 employees and has 4,185 associated physicians. Methodist has been recognized as the top hospital system in Houston & Texas by US News & World Report and honored as the top ranked healthcare provider to work for by Fortune Magazine. The Methodist Hospital’s payor mix for Medicaid is 4.94% and 2.87% self-pay and San Jacinto’s payor mix for Medicaid is 12.87% and 11.31% for self-pay. The Methodist Hospital is the only private hospital that provides acute psychiatric services in the Texas Medical Center as is San Jacinto in its community.

Intervention(s): By facilitating effective transitions of care to behavioral health and primary care through locations within Harris County including HARRIS HEALTH SYSTEM, MHMRA, private physicians, and SJMH Family Medicine Residency physicians we seek to help patients navigate a complicated health-care landscape, participate in mental health choices, increase their self-efficacy, provide better quality of life and prevent readmissions and prevent adverse outcomes of incarceration, chemical dependency or suicide. Outpatient Service Availability is limited, and so we hope to leverage the community mental health workers to connect and encourage care within existing primary care and mental health resources. The program will advocate primary care expansion for mental health, through the use of treatment algorithms and perhaps by embedding counselors within a primary practice who could bill “incident to” for supervised service.

Target Population: About 140,000 adults in Harris County suffer from severe mental illness, while almost half of these adults had no access to treatment from the public or private health system. Our target population is defined as those individuals who suffer from any behavioral health related condition and who are seeking care in our facilities, more specifically those who are covered by Medicaid or without insurance coverage. At The Methodist Hospital & San Jacinto Methodist Hospital we serve those with behavioral health as detailed below:

| ED Visits - Self Pay & Medicaid | 32,319 |
| ED Visits - Behavioral Health - Self Pay & Medicaid | 879 |
| ED Admissions - Self Pay & Medicaid | 3,596 |
| ED Admissions - Behavioral Health - Self Pay & Medicaid | 278 |
| IP Admissions - Self Pay & Medicaid | 8,024 |
| IP Admissions - Behavioral Health - Self Pay & Medicaid | 540 |
Category 1 or 2 expected patient benefits: Our project will include a number program innovation and redesign efforts. These include ensuring we have recruiting qualified people to intervene and guide care, educate staff, identify community partners, re-engineering our discharge planning process to ensure patients transition into the ambulatory care setting successfully, setting up care coordination protocols to make sure we identify patient accurately who need our assistance and following our system’s CQI efforts of plan, do, check and act to ensure we’re achieving our expected outcomes for this target population. It is our goal to impact an estimated 50% of the patients who suffer from behavioral health issues and who visit our EDs and inpatient psychiatric units by year 3. That equates to over 2,100 total patients, over 700 who are covered by Medicaid or without coverage. We expect that number to increase to 60% in year 4 (over 3,400 total, over 1,100 Medicaid / self pay) and to 80% in year 5 (over 3,600, over 1,200 Medicaid / self pay). We also expect to see a 10% reduction in all-cause readmissions in year 4 and a 20% improvement in all-cause readmission in year 5 for our target population.

Category 3 outcomes: IT 1.18 Our goal is that in the first year we will coordinate care follow-up post discharge to 20% and increase this to 80% by year 5.
Project Option 2.17.1 - Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Implement Care Transition Coordination

Unique Project ID#: 137949705.2.1
Performing Provider Name / TPI: The Methodist Hospital / 137949705

Project Description:

Preventing Behavioral Health Readmissions by Implementing Care Transition Coordination

According to Healthy Peoples 2010 Mental Illness is on par with heart disease and cancer as a cause for disability. 140,000 residents of Harris County suffer from Mental Illness.¹ Many have no access to treatment from the public or private health system. Almost 20,000 youths in Harris County are in need of treatment while only 24% of cases were addressed.²

Currently in Harris County there are limited locations for follow-up mental health care services. The MHMRA services are provided through an office in Pasadena or League City, which is more than 30-45 minutes away and many patients have limited transportation and other barriers to follow up mental health care. Care can be received at the Harris Health System clinic in Baytown where existing patients have access to a visiting Psychiatrist on site 1 half-day per week. This same scenario of limited facilities and physicians to provide ongoing chronic behavioral health care services plays itself out in Central and Northwest Harris County.

There are many barriers to effective mental health care provision. These can be grouped as patient factors, physician factors and system factors. Primary care and primary care psychiatry working together are necessary to address the care of affective and other mental illnesses.³

The intervention proposed will involve the use of community mental health workers with Behavioral Health Education who can coordinate the care of adult patients through the transition from inpatient care to outpatient levels of care including both mental health and primary care follow up. It will also include promoting and monitoring attendance at community settings such as chemical dependency programs. The community mental health workers will be located at The Methodist Hospital, San Jacinto Methodist Hospital and Methodist Willowbrook Hospital and will receive their case load from hospital discharges, referred discharges from HARRIS Harris Health System who reside in these communities, and referrals from the Emergency Department. The community mental health workers will have access to hospital medical records including discharge planning, Ideally the information from SJMH and Harris Health System may be available through shared information systems between EPIC software and Methodist IT platforms. This will involve a software program called Medicity, which is contained in Methodist Connect and Harris County Health Connect. It will also involve securing patient consent for this level of information exchange.

The community mental health worker will then follow recognized treatment protocols to query patient compliance with treatment and contact the primary care physician or mental health specialist. The care transition manager may refer to specialized disease management programs, such as those for alcohol or chemical dependency. To assist primary care physicians providing mental health follow up, treatment algorithms can guide treatment selection and increased quality and consistency of treatment, provide better clinical outcomes, and more efficient use of health care resources. The care will be directed toward the use guidelines including the Texas Medication Algorithm Project, (TMAP).⁴ It will also include recommending sequenced care

¹
²
³
⁴
such as the Sequenced Treatment Alternatives to Relieve Depression, (STAR-D), which assist patients and clinicians implementing “next step” treatment options. It involves patient-choice and buy-in as well as use of patient-completed rating scales such as the “Quick Inventory for Depressive Symptoms” to monitor response to treatment and alert when urgent outpatient mental health care or crisis intervention is necessary. Objective measurements such as this can assist the transitions nurse in evaluating severity or priority.

By facilitating effective transitions of care to behavioral health and primary care through locations within Harris County including Harris Health System, MHMRA, private physicians, and SJMH Family Medicine Residency physicians we seek to help patient navigate a complicated health-care landscape, participate in mental health choices, increase their self-efficacy, provide better quality of life and prevent readmissions and prevent adverse outcomes of incarceration, chemical dependency or suicide.

The costs associated with this program will include IT costs, Space Costs and Salary Costs.

Goals and Relationship to Regional Goals:
This project meets the following regional goals:

This program would meet the following three regional health goals #1 by leveraging and improving on existing programs and infrastructure. #2 by increasing access to primary and specialty care services, with a focus on underserved and the Medicaid populations. It will ensure patients receive the most appropriate and accessible care for their condition, regardless of where they live or their ability to pay. #3 It will transform from disease-centered emergency room care to patient-centered preventive approach to behavioral health care. It also reduced duplication of uncoordinated services currently received from county and private health care.

Challenges:
- Recruitment of qualified community mental health workers
- Recruitment of psychiatrists & acute care nurse practitioners
- Patient compliance

5-Year expected outcome for Performing Provider and Patient:
Focused effort to transition patients from the acute and ED setting with behavioral health conditions will improve outcomes and reduce costs. We aim to reduce repeated admission to our inpatient psychiatric units and reduce repeat emergency room visits from our targeted population. Patients will benefit from a more hands-on, compassionate and integrated care coordination system for behavioral healthcare. This should translate to a reduction of demand for incarcerated patients with mental illness and an improvement in the daily productivity from those who benefit from our program.

Starting Point/ Baseline:
We can get a partial measure of the problem based on recent ED and inpatient admissions. To this we may add utilization at nearby facilities, but the data is not available at present. At San Jacinto Methodist Hospital in 2011 there were 443 ED admissions with a primary diagnosis of a Mental Health condition, (187 were self-pay and Medicaid) resulting in a financial loss of $119k. At The Methodist Hospital there were 612 ED admissions with a primary diagnosis of a Mental Health condition resulting in a loss of $1.154M. At Methodist Willowbrook Hospital there were 160 ED admissions with a primary diagnosis of a Mental
Health condition resulting in a loss of $6k. This may be an underestimate since it only captures primary diagnoses. There were 709 behavioral health admissions, 296 of which were self-pay and Medicaid, for a net financial loss of $324k.

It is estimated that 30-50% are readmitted within a one-year period based on national literature. Outpatient Service Availability is limited, and so we hope to leverage the community mental health workers to connect and encourage care within existing primary care and mental health resources. The program could advocate primary care expansion for mental health, through the use of treatment algorithms and perhaps by embedding counselors within a primary practice who could bill “incident to” for supervised service.

**Rationale:**
As referenced above, residents of Harris County have difficulty accessing mental health services.

The stated principles of the Harris County behavioral health system include quick, easy and convenient entry into services, full range of services and minimal financial barriers to necessary services. The principles promote recovery, continuity of care, family integration in care, evidence based care, and where possible co-location of behavioral health and general health care. HC Behavioral Health promotes stability of behavioral health conditions by decreasing relapse of mental illness and substance abuse.

A designated mental health professional provides oversight to the care-management team to provide this collaborative care. There are many examples of collaborative care management.

**Project Components:**

a. Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, ambulatory care, behavioral health and community-based non-medical supports
   a. We will develop a team of clinical leaders from various care settings to ensure care delivery is integrated and coordinated.

b. Conduct an analysis of the key drivers of 30-day hospital readmissions for behavioral health conditions using a chart review tool
   a. We will review each chart and develop a trending report of complications from each patient who is readmitted. Our teams will use this information to ensure we are incorporating the appropriate care pathways while the patients are in the hospital and we will also make any changes to our discharge planning process as needed to reduce readmissions.

c. Identify baseline mental health and substance abuse conditions at high risk for readmissions
   a. We will begin with a retrospective review of all behavioral health related readmissions to identify trends. On a go-forward basis, we will review each chart and develop a trending report of complications from each patient who is readmitted. These reports will be updated to ensure we are identifying those patients who are at high risk for readmissions.

d. Review best practices for improving care transitions from a range of evidence-based or evidence-informed models
   a. Our teams will work collaboratively with other groups focused on reducing readmissions and incorporate their best practices to our patient population.
e. Identify and prioritize evidence-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions.
   a. Our teams will utilize the plan, do, check, act approach of continuous quality improvement for this project. Using this approach will ensure that we are identifying and prioritizing care transactions and reduce readmissions.
   f. Implement two or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population.
   g. Conduct quality improvement for project using methods such as rapid cycle improvement.

The project will focus primarily on items b, c, d and e of the above listed components.

**Unique community need identification number the project addresses:** CN.3 - Inadequate access to behavioral health care

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

This project represents the first time a focused, coordinated care navigation effort has been targeted at patients who suffer from behavioral health conditions. We feel that this project will significantly reduce unnecessary emergency department utilization & repeat admissions into inpatient psychiatric units.

Our hospital system receives monies from the CMS innovation grant program for 2 projects related to early recognition of Sepsis and Delirium. Neither of these federally funded projects conflict with the scope of the proposed DSRIP project.

**Related Category 3 Outcome Measures:**

OD-1: Primary Care and Chronic Disease Management
IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)

**Reasons/rationale for selecting the outcome measures:**
Rationale for choice of using one standalone measure is that is most specific for the intervention. It has been well established that unnecessary readmissions can be prevented by implementing various measures to ensure outpatient follow-up.xi

Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.
Our goal is that by year four we will have 60% with follow up within 30 days, and by year 5 we will have 80%.

Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.
As it is difficult to arrange appointments so close to discharge because of patient and physician factors, our goal is that by the fourth year we will have 40% follow up within seven days and by the fifth year, 50%.

**Relationship to other Performing Providers Projects within the RHP:**
The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Multiple other Behavioral Health Innovations include care navigators, transition coaches, or case managers. We seek to participate in lessons-learned with all of these programs. We also plan to collaborate with entities receiving Federal SAMSHA funding such as Community Mental Health services block grant, Substance Abuse Prevention and Treatment Block Grant or other mental health and substance abuse grants, (Harris County Adult Treatment STAR Drug Courts, TI021529). The transition nurse would be reaching out to connect the patient with right source of care.

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

**Project Valuation:**
Our project’s sole focus is the improvement of care hand-offs of behavioral health patients from the acute setting, be that inpatient or emergency department, to the appropriate ambulatory or home care setting. The costs associated with the ineffective current manner in which such care is provided today adds to the unnecessary costs of care that the state is paying each year. As such, we feel that this project covers the costs that our organization will incur to develop such a program plus allow for incentive to use such resources effectively and efficiently.

Our organization shares the need to improve the way that behavioral health care is delivered because we lose hundreds of thousands of dollars providing such care each year. As such, our incentives are perfectly aligned with the goals of the state’s DSRIP project intentions to not only enhance care, but better utilize state taxpayer monies at the same time.

All milestones and metrics were given equal weight and valuation for this project.
### Preventing Behavioral Health Readmissions by Implementing Care Transition Coordination

**The Methodist Hospital**

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

| IT 1.18 | 137949705.3.1 | Follow up after Hospitalization for Mental Illness |

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

#### Milestone 1

**[P-1]** Establish Team to support or lead project

**Metric 1** [P-1.1]: Establishment of Team
Baseline/Goal: 100% complete Data Source: program documents. List of team members

Milestone 1 Estimated Incentive Payment: 549,639

#### Milestone 2

**[P-2]**: Collect information and/or analyze data on factors contributing to preventable readmissions within 30 days.

**Metric 1** [P-2.4]: Develop an electronic report on readmission data
Baseline: Report developed and criteria established. Data Source: program documents.

Metric 2 [P-2.5]: Chart review Reports
Baseline: List of reports used on a daily basis to improve transition coordination. Data Source: program documents.

#### Milestone 8

**[P-15]**: Educate appropriate clinical staff on key contributing factors to preventable readmissions.

**Metric 1** [P-15.1]: X% of key clinical staff completing educational sessions
Baseline/Goal: 50% of emergency medicine, internal medicine & behavioral health clinicians complete education.

Data Sources: Internal hospital records/documentation; Training curricula

Milestone 8 Estimated Incentive Payment: $905,288

#### Milestone 9

**[P-17]**: Re-engineer hospital discharge process for all admitted patients.

**Metric 1** [P-17.1]: Development of high-risk tool and discharge checklist
a. Data Source: EMR Documentation of high risk tool and discharge checklist including medication reconciliation

Milestone 9: Estimated Incentive Payment (maximum amount):

#### Milestone 12

**[P-23]**: Train care transition nurses on standard use of evidence-based care transition tool and framework.

**Metric 1** [P-23.1]: X% of post-acute partners trained
Baseline/Goal: 100% of 4 transition nurses trained Data Source: Internal Hospital Records.

Milestone 12 Estimated Incentive Payment: $848,707.25

#### Milestone 13

**[P-28]**: Gap analysis regarding patient communication with doctors, nurses, and/or discharge information.

**Metric 1** [P-28.1]: Analysis complete
Baseline/Goal: 100% complete Data Source: Internal hospital records/documentation

Milestone 13 Estimated Incentive Payment: $848,707.25

#### Milestone 14

**[P-30]**: Participate in bi-weekly interactions (conference calls, or webinars) with other

#### Milestone 16

**[P-32]**: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

**Metric 1** [(P-32.1)] Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in learning collaborative

Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

Milestone 16: Estimated Incentive Payment (maximum amount): $1,290,035
### PREVENTING BEHAVIORAL HEALTH READMISSIONS
**BY IMPLEMENTING CARE TRANSITION COORDINATION**
(Mental Health Program Innovation and Redesign through use of Psychiatric Care Managers)

**The Methodist Hospital**

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>137949705.3.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.17.1</td>
<td>IT 1.18</td>
<td>Follow up after Hospitalization for Mental Illness</td>
</tr>
</tbody>
</table>

#### Year 2
(10/1/2012 – 9/30/2013)

**Metric 3 [P-2.6]:** Determine baseline metric for all cause 30 day readmissions
Data Source: program documents.

**Metric 4 [P-2.7]:** Identification of key factors that increase the likelihood of preventable 30 day readmissions for individuals with mental health and substance use disorders
Baseline: Development of factors that increase likelihood of readmission by working committee.
Data Source: program documents

<table>
<thead>
<tr>
<th>Milestone 10: (P-20) Identify community-based care transition partners.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1: (P-20.1) Number of care transition partners</td>
</tr>
<tr>
<td>Metric 2: (P-20.2) Number of partner post-acute facilities</td>
</tr>
</tbody>
</table>

| Milestone 10 Estimated Incentive Payment (maximum amount): |
| $905,288 |

**Milestone 11: (P-23) Train care transition nurses on standard use of evidence-based care transition tool and framework.**

<table>
<thead>
<tr>
<th>Metric 1: 50% of 4 transition nurses trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Internal Hospital Records.</td>
</tr>
</tbody>
</table>

| Milestone 11 Estimated Incentive Payment (maximum amount): |
| $905,288 |

#### Year 3
(10/1/2013 – 9/30/2014)

**Milestone 10 Estimated Incentive Payment:** $549,639

**Milestone 3:** (P-4) Hire clinician(s) with care transition/disease management expertise.

<table>
<thead>
<tr>
<th>Metric 1 [P-4.1]: Position offer letters.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline/Goal: 100% completion of budgeted hiring (15 FTEs) or appropriate FTEs based on realized providers and the RHP to promote collaborative learning around shared or similar projects. Including: 1) sharing challenges &amp; solutions 2) sharing results and quantitative progress on new improvements that the provider is testing; and 3) identifying a new improvement and publicly commit to testing it in the week to come.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metric 1 [P-30.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline / Goal: 100% complete</td>
</tr>
<tr>
<td>Data Source: Attendance record logs and conference call meeting minutes</td>
</tr>
</tbody>
</table>

| Milestone 14 Estimated Incentive Payment: |
| $848,707.25 |

#### Year 4
(10/1/2014 – 9/30/2015)

**Milestone 17 Estimated Incentive Payment:** $1,290,035

**Metric 1 [I-43.1]:** Metric: 20% decrease in preventable all-cause admissions and readmissions to psychiatric and other inpatient facilities;

**Goal: 20% above baseline, average from years DY 2 & DY 3.**

| Data Source: Claims/encounter and clinical record data; anchor hospital and other partner hospitals, local MH authority and state MH(CARE)data system records |

| Milestone 14 Estimated Incentive Payment: |
| $848,707.25 |

#### Year 5
(10/1/2015 – 9/30/2016)

**Metric 1 [P-30.2]:** Share challenges and solutions successfully during this bi-weekly interaction.

| Baseline / Goal: 100% complete |
| Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider, summarized at quarterly intervals |

| Milestone 14 Estimated Incentive Payment: |
| $848,707.25 |

**Milestone 17 Estimated Incentive Payment:** $1,290,035
<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>IT 1.18</th>
<th>137949705.3.1</th>
<th>Follow up after Hospitalization for Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 1: Preventable All-Cause Admissions and Readmissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1: [I-43.1]: Metric: 10% decrease in preventable all-cause admissions and readmissions to psychiatric and other inpatient facilities; Goal: 10% above baseline, average from years DY 2 &amp; DY 3. Data Source: Claims/encounter and clinical record data; anchor hospital and other partner hospitals, local MH authority and state MH(CARE)data system records</td>
<td>Milestone 15 Estimated Incentive Payment: $848,707.25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 5: [P-6] Identify evidence-based frameworks that support seamless care transitions and impact preventable 30-day readmissions. Metric 1: [P-6.1] Selection of an</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>137949705.2.1</td>
<td>2.17.1</td>
<td>A-G</td>
<td>PREVENTING BEHAVIORAL HEALTH READMISSIONS BY IMPLEMENTING CARE TRANSITION COORDINATION (Mental Health Program Innovation and Redesign through use of Psychiatric Care Managers) The Methodist Hospital 137949705</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s): IT 1.18</td>
<td>137949705.3.1</td>
<td>Follow up after Hospitalization for Mental Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td>evidence based framework. Baseline/Goal: 100% developed Data source: Meeting minutes selecting an evidence based framework. Milestone 5 Estimated Incentive Payment $549,639</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 6 [P-7]</strong>: Develop operations manual for care transitions intervention with administrative protocols and clinical guidelines Metric 1 [P-7.1]: Develop a written operations manual Baseline/Goal: 100% complete Data Source: Written operations manual Milestone 6 Estimated Incentive Payment: $549,639</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 7 [P-10]</strong>: Develop plan for hospital care transition process Metric 1: [P-10.1] Care management tool Baseline / Goal: 100% complete Data Source: Written process &amp; protocol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Outcome Measure(s)</td>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>----------</td>
<td>---------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Related Category 3</td>
<td>IT 1.18</td>
<td>Follow up after Hospitalization for Mental Illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 2: [P-10.2] Transition Process Improvement Plan</td>
<td>137949705.3.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline / Goal: 100% complete</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Written process &amp; protocol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 7 Estimated Incentive Payment: $549,639</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $3,847,472</td>
<td>Year 3 Estimated Milestone Bundle Amount: $3,621,150</td>
<td>Year 4 Estimated Milestone Bundle Amount: $3,394,829</td>
<td>Year 5 Estimated Milestone Bundle Amount: $2,580,070</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5):** $13,443,521
Extrapolated from US prevalence rate in Methodist Hospital Community Needs Assessment 2011

Local Plan Review, History and Organizational Review FY 2006-7


Rush AJ. The 16-item Quick Inventory of Depressive Symptomatology (QIDS), Clinician Rating (QIDS-C), and Self-Report (QIDS-SR): a psychometric evaluation in patients with chronic major depression. Biological Psychiatry, 54 (2003), pp. 573–583


J. Schaefer, C. Davis Case management and the chronic care model: a multidisciplinary role Lippincotts Case Manag, 9 (2) (2004), pp. 96–103


The University of Texas Health Science Center - Houston

Pass 1
Project Option 2.1.3-2.1 Enhance/Expand Medical Homes: UT Health Regional Specialty Care Centers

Unique RHP Project ID: 111810101.2.1
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider: UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s): The UT medical homes will include services in the areas of dentistry, women's health, maternal-fetal health, trauma and rehabilitation, sports medicine/orthopedics, behavioral and mental health, cardiovascular diseases, neurosciences, pediatrics and geriatrics. This Multispecialty Physician Group will provide an extensive network of specialty support centers for primary care providers, built on the concept of an "advanced medical home". Patients will be assigned to a primary care provider within the UT Physicians system of primary and specialty care physicians.

Need for the project: In our region there is inadequate access to primary care, insufficient access to care coordination practice management and integrated care treatment programs, and lack of access to programs providing health promotion education, training and support. Medical Home models provide accessible, continuous, coordinated and comprehensive patient-centered care that is managed centrally by a primary care physician with the active involvement of non-physician practice staff.

Target Population: The service areas of our 4 outlying clinics include health professional shortage areas, and medically underserved areas and populations. In FY 2012, UTP provided 321,716 patient visits and expects to add another 80,000 (most of which are expected to be Medicaid clients) by DY5 for over 400,000 patient visits. Using the Harris County rate (14.5%) of Medicaid clients, there are an estimated 1,423,176 Medicaid clients living within our service areas.

Category 1 or 2 expected patient benefits:
By the end of DY5, we expect to have 9,000 patients assigned to medical homes, with over 8,000 receiving their first appointment in their medical home within 120 days of assignment, and 6,400 having had a visit in their medical home. Using a very conservative estimate of 23%, 2,070 of the patients assigned to a medical home would be Medicaid patients.

Category 3 outcomes:
Our goals are to improve patient satisfaction scores for getting timely care, appointments, and information (using the supplemental module for the adult CG-CAHPS survey) for patients of UT Physician Clinics, who were assigned to a medical home (IT-6.1) and to improve diabetes care by reducing HbA1c levels (>9.0%) (IT-1.10).
Project Option 2.1.3 – Enhance/Expand Medical Homes: UT Health Regional Specialty Care Centers

Unique RHP Project Identification Number: 111810101.2.1
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 2.1 Enhance/Expand Medical Homes (Option 2.1.3)

The practice at UT Physicians' Clinics serves areas designated as primary care health professional shortage areas (HPSAs), medically underserved areas (MUAs), and medically underserved populations (MUPs). The Bayshore Clinic service area includes several HPSAs (CT 3207, CT 3208, CT 3218, CT 3219, CT 3220, CT 3333). The Bellaire Clinic service area includes several MUPs (CT 4211, CT 4213, CT 4214, CT 4215, CT 4216). Also, the Cinco Ranch Clinic (CT 6731, CT 6733) and the Sienna Clinic (CT 6746) service areas include MUAs.

The practice at UT Physicians’ clinics will be transformed to operate on the concept of patient-centered medical homes. The medical homes will include services in the areas of dentistry, womens' health, maternal-fetal health, trauma and rehabilitation, sports medicine/orthopedics, behavioral and mental health, cardiovascular diseases, neurosciences, pediatrics and geriatrics. UT Health already has and/or will establish state-of-the-art top-ranking Regional Centers in Dental Health, Maternal-Fetal Health, Women, Child and Adolescent Health, Healthy Aging, Neurosciences, Sports Medicine, Trauma and Rehabilitation, Behavioral and Mental Health, Heart and Vascular Disorders and Students' Health. This Multispecialty Physician Group will provide an extensive network of specialty support centers for primary care providers, built on the concept of an "advanced medical home".

Patients will be assigned to a primary care provider within the UT Physicians system of primary and specialty care physicians. Members of staff will be placed into multidisciplinary care teams that manage a panel of patients; each with a defined role and tasks would be divided among care team members to reflect the skills, abilities, and credentials of team members. Patients will be linked to a provider and care team so both patients and provider/care team recognizes each other as partners in care. By means of phone, e-mail, or in-person visits, patients will have continuous access to their medical home. This program will rely on the National Committee for Quality Assurance (NCQA) guidelines (http://www.ncqa.org/Portals/0/Programs/Recognition/RPtraining/PPCPCMH_Training.pdf), which include: 1. improved access and communication, 2. use of data systems to enhance safety and reliability, 3. care management, 4. patient self-management support, 5. electronic prescribing, 6. test tracking, 7. referral tracking, 8. performance reporting and improvement, and 9. advanced electronic communications. (See related project MS1 UT-Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center, and projects C5-C9 and CL3 for chronic disease management programs for asthma, COPD, CHF, diabetes, and hypertension.) Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.
Goal and Relationship to Regional Goals:
Project Goal:
To provide a primary care "home base" for patients, who will be assigned a health care team that tailors services to their unique health care needs, effectively coordinates their care across inpatient and outpatient settings, and proactively provides preventive, primary, routine and chronic care.
This project addresses the following regional goal:
Redesigning of the practice at UT Health on the PCMH concept fits right with the regional goal to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system."

Challenges:
Need: 1) Inadequate access to primary care. 2) Insufficient access to care coordination and integrated care treatment programs. 3) Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs.
Implementation: 1) Staff motivation and ability to work as a care team. 2) Availability of manpower to implement staffing plan.
With the Medical Homes project patients will have access to comprehensive care in a coordinated manner, including preventive and self-management education programs. Providers will be assembled to work in teams to deliver personalized and effective care to enrolled patients.

5-Year Expected Outcome for Provider and Patients:
Our practice will have been transformed based on the concept of the patient centered medical homes, leading to better coordination of patient care, increased access, and improved patient satisfaction. In addition to benefiting the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base of UTP clinics, this model of care will be available to another potential 1,423,176 Medicaid and Medicaid-eligible residents living within the service areas of the UT Physician Clinics, to whom our services will be marketed. With the expansion of primary and specialty care access, we expect to provide patient care to an additional 80,000 patient visits by the end of DY5, most of which are expected to be Medicaid/Medicaid-eligible clients (based on the demographics of the UTP clinics service areas). The transition to the team-based, proactive healthcare delivery model of medical homes, all conveniently located where there is great need, will help to address many of the barriers that the low-income population typically encounter in getting the appropriate care, facilitating better health outcomes.
By the end of DY5, we expect to have 9,000 patients assigned to medical homes, with over 8,000 receiving their first appointment in their medical home within 120 days of assignment, and 6,400 having had a visit in their medical home. Using a very conservative estimate of 23%, 2,070 of the patients assigned to a medical home would be Medicaid patients.

Starting Point/Baseline:
This is a new program. Consequently our baseline is zero. The targets for our milestones and metrics are based upon the current number of unique patients with a diagnosis of asthma, hypertension, diabetes, CHF, or COPD, which is 12,879.
Rationale:

Project Components:
Through the UT Health Regional Specialty Care Centers Program, we propose to meet all required project components listed below.

a) UTP will develop and implement policies and systems to enhance patient access to the medical home. This enhanced access will include open scheduling, expanded hours to include evening and Saturday hours, a new online patient portal, and the ability for patients to communicate with their healthcare team via email.

b) Based on staff capacity, demographics, and diseases, practice supply and demand, UTP will determine the appropriate panel size for primary care provider teams and assign patients to a primary care provider within the medical home.

c) UTP will restructure the current organization of care into multidisciplinary care teams that will manage a panel of patients where providers and staff operate at the top of their license. Roles and tasks of care team members will reflect their skills, abilities, and credentials.

d) UTP will link patients to a provider and care team so both patients and provider/care team recognizes each other as partners in care.

e) Using the enhanced access policies and systems, UTP will assure that patients are able to see their provider or care team whenever possible. By promoting the expanded access available through the medical home model (open scheduling, nurse advise line, the online patient portal, and email contact with the care team) established patients will have 24/7 continuous access to their care teams.

f) UTP’s quality improvement office will conduct QI for each of the clinics providing specialty care using methods such as rapid cycle improvement.

Milestones and Metrics:
For the UT Health Regional Specialty Care Centers Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:
**Milestone 1** [P-X1] Designate/hire personnel or teams to support and/or manage the project/intervention

Metric 1 [P-X1.1] Project managers, personnel assigned to teams, and team responsibilities

**Milestone 2** [P-X2] Conduct planning meetings with representatives of stakeholder groups (physicians, nurses, other clinical support, administration) to establish an implementation plan for the medical homes practice, which will provide coordinated, continuous support to UTP patient populations.

Metric 1 [P-X2.1] Implementation plan (eligibility criteria, implementation components, responsibilities, and timeline).

**Milestone 3** [P-5.]: Determine the appropriate panel size for primary care provider teams, potentially based on staff capacity, demographics, and diseases.

Metric 1 [P-5.1.]: Determine Panel size

**Milestone 4** [P-4.]: Develop staffing plan to expand primary care team roles; Expand and redefine the roles and responsibilities of primary care team members.

Metric 1 [P-4.1.]: Expanded primary care team member roles

**Milestone 5** [P-2.]: Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Metric 1 [P-2.1.]: UT Physicians policies on medical homes

**Milestone 6** [P-3.]: Reorganize staff into primary care teams responsible for the coordination of patient care.

Metric 1 [P-3.1.]: Primary care teams

**Milestone 7** [P-9.]: Train medical home personnel on PCMH change concepts.

Metric 1 [P-9.1.]: Number of medical home personnel trained

**Improvement Milestones and Metrics:**

**Milestone 8** [I-12.]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes.

Metric 1 [I-12.1.]: Number or percent of eligible patients assigned to medical homes, where “eligible” is defined by the UT Physicians

**Milestone 9** [I-13.]: New patients assigned to medical homes receive their first appointment in a timely manner

Metric 1 [I-13.1.]: Improve number or percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days

**Milestone 10** [I-16.]: Increase number or percent of enrolled patients’ scheduled primary care visits that are at their medical home

Metric 1 [I-16.1.]: Percent of primary care visits at medical home

**Milestone 11** [I-12.]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes.

Metric 1 [I-12.1.]: Number or percent of eligible patients assigned to medical homes, where “eligible” is defined by the UT Physicians

**Milestone 12** [I-13.]: New patients assigned to medical homes receive their first appointment in a timely manner

Metric 1 [I-13.1.]: Improve number or percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days
Milestone 13 [I-16.]: Increase number or percent of enrolled patients’ scheduled primary care visits that are at their medical home
Metric 1 [I-16.1.]: Percent of primary care visits at medical home

Unique community need identification numbers the project addresses:
This project addresses community needs CN.1 (Inadequate access to primary care), CN.7 (Insufficient access to care coordination practice management and integrated care treatment programs), and CN.20 (Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs).

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project represents a new initiative. UT Physicians practice is not currently organized on the medical home model. Hence, UT Physicians proposes to provide better coordinated care for its patients by transitioning to a patient-centered and team-based model of care.

Related Category 3 Outcome Measure(s):
OD-6 Patient Satisfaction
  • IT-6.1 (1) Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone measure)
    Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a stand-alone measure). Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients: (1) are getting timely care, appointments, and information (already established patients at UTP Clinics, who are not cancer surgery patients and who were assigned to a medical home)

OD-1 Primary Care and Chronic Disease Management
  • IT-1.10 Diabetes care: HbA1c poor control (>9.0%)233- NQF 0059 (Standalone measure)
    Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.

Relationship to other Projects:
1.1 (C3) - The expanded capacity to deliver primary care will be necessary for the redesign of the UT Physician practice as patient-centered medical homes, ensuring that there are enough primary care physicians for patient panels.
1.2 (A2, SPH1) - The innovative residency program and the training of community health workers will ensure availability of human resources to staff the medical homes.
1.3 (C12) - The disease management registry will be a useful resource for efficient medical home assignment and disease management within the medical homes.
1.7 (A1) - Telemedicine increases the capacity of UT Medical Homes to deliver both primary and specialty care services to patients when and where needed.
1.10 (MS1) - With QI support from project MS1, UT Health will be better equipped to deliver optimum care to patients.

2.2 (C5-9, CL3) - A significant number of patients seen regularly in primary care have chronic diseases requiring more effective care for patients enrolled in UT Medical Homes, for which the chronic care model is well suited.

2.9 (A4) - The care navigation project will facilitate the move into a primary care setting for frequent ED users by getting them enrolled in primary care within the UT Medical Homes.

2.11 (C10) - The medication management program will be a useful resource for all care providers in the UT Medical Homes practice.

2.12 (A3, CL1, CL2, MS4) - The various care transitions projects will ensure there is no interruption in the care continuum for patients as they transit from one form of care to the other within the medical homes.

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

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

**Plan for Learning Collaborative:**

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

**Project Valuation:**

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. **Transformational Impact** (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).
2. **Population Served/Project Size** (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.

3. **Aligned with Community Needs** (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. **Cost Avoidance** (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects.

5. **Partnership/Collaboration** (Weight = 10%): *This was not rated*, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. **Sustainability** (Weight = 15%): *This was also not rated*, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>111810101.2.1</th>
<th>Option 2.1.3</th>
<th>2.1.3 (A-F)</th>
<th>UT Health Regional Specialty Care Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTHealth, UTPhysicians</td>
<td>111810101.3.16</td>
<td>IT-6.1 (1)</td>
<td>IT-1.10</td>
<td>Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone measure) Diabetes care: HbA1c poor control (&gt;9.0%)233-NQF 0059 (Standalone measure)</td>
</tr>
</tbody>
</table>

**Milestone 1** [P-X1.1.]: Designate/hire personnel or teams to support and/or manage the project/intervention

**Metric 1** [P-X1.1.]: Project managers, personnel assigned to teams, and team responsibilities

Goal: 2 project managers, 4 clinical leaders, 1 trainer, additional team members designated by the project managers and team leaders.

Data Source: Program documentation

Milestone 1 Estimated incentive payment: $790,223

**Milestone 2** [P-X2.1.]: Conduct planning meetings with representatives of stakeholder groups (physicians, nurses, other clinical support, administration) to establish an implementation plan for the medical home practice, which will provide coordinated, continuous support to UTP patient populations.

**Metric 1** [P-X2.1.]: Implementation plan (eligibility criteria, implementation components, responsibilities, and timeline).

<table>
<thead>
<tr>
<th>Year 2</th>
<th>(10/1/2012 – 9/30/2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 5 [P-2.1.]: Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.</td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-2.1.]: UT Physicians policies on medical home Goal: Create new policies and obtain final approval for the protocols and updated policies and procedures for medical homes Data Source: UT Physicians’s “Policies and Procedures” documents Milestone 5 Estimated incentive payment: $1,188,305</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 3</th>
<th>(10/1/2013 – 9/30/2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 6 [P-3.]: Reorganize staff into primary care teams responsible for the coordination of patient care.</td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-3.1.]: Primary care team Goal: Multidisciplinary teams will be built around the 5 chronic disease states targeted (asthma, diabetes,</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 4</th>
<th>(10/1/2014 – 9/30/2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 8 [I-12.]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes.</td>
<td></td>
</tr>
<tr>
<td>Metric 1 [I-12.1.]: Number or percent of eligible patients assigned to medical homes, where “eligible” is defined by the UT Physicians Baseline: The baseline is zero, since this is a new program. Goal: 4,500 Data Source: Practice management system, EHR, or other documentation as designated by UT Physicians Milestone 8 Estimated incentive payment: $1,235,837</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 5</th>
<th>(10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 11 [I-12.]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes.</td>
<td></td>
</tr>
<tr>
<td>Metric 1 [I-12.1.]: Number or percent of eligible patients assigned to medical homes, where “eligible” is defined by the UT Physicians Goal: Additional 4,500 over DY4 Data Source: Practice management system, EHR, or other documentation as designated by UT Physicians Milestone 11 Estimated incentive payment: $1,183,023</td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 12** [I-13.]: New patients assigned to medical homes receive their first appointment in a timely manner

**Metric 1** [I-13.1.]: Improve number or percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120 days

Goal: Additional 4,050 over DY4

Milestone 12 Estimated incentive payment: $1,120,023

Regional Healthcare Partnership Plan Region 3 1526

---
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>111810101.3.16</th>
<th>111810101.3.17</th>
<th>Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone measure) Diabetes care: HbA1c poor control (&gt;9.0%)233- NQF 0059 (Standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>IT-6.1 (1)</td>
<td>IT-1.10</td>
<td>Year 3 (10/1/2013 – 9/30/2014) Year 4 (10/1/2014 – 9/30/2015) Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Goal: Our current practice does not apply medical home processes to chronic disease management. The goal is to develop and document a specific plan to make the transition from usual care to specialty care centers. Data Source: UT Physicians' report, policy, contract or other documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 2 Estimated incentive payment: $790,223</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 3 [P-5.]: Determine the appropriate panel size for primary care provider teams, potentially based on staff capacity, demographics, and diseases. Metric 1 [P-5.1.]: Determine Panel size Baseline/Goal: Determine panel sizes for care teams targeting 5 disease states (asthma, diabetes, hypertension, CHF, and COPD) Data Source: Panel size determination tool, patient registry, EHR, or needs assessment tool to assess appropriate panel size based on patient needs (as determined by the clinic) for hypertension, CHF, COPD) at each of the 4 community clinics Data Source: UT Physicians staffing records and other program documentation Milestone 6 Estimated incentive payment: $1,188,305</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 7 [P-9.]: Train medical home personnel on PCMH change concepts. Metric 1 [P-9.1.]: Number of medical home personnel trained Goal: 10 FTE’s trained and essential staff at 4 community clinics Data Source: Training records and HR documents Milestone 7 Estimated incentive payment: $1,188,304</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 9 Estimated incentive payment: $1,235,837</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 10 [I-16.]: Increase number or percent of enrolled patients’ scheduled primary care visits that are at their medical home Metric 1 [I-16.1.]: Percent of primary care visits at medical home Goal: 80% Data Source: Practice management system, EHR, or other documentation as designated by Performing Provider Milestone 10 Estimated incentive payment: $1,235,836</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 13 Estimated incentive payment: $1,183,023</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 13 [I-16.]: Increase number or percent of enrolled patients’ scheduled primary care visits that are at their medical home Metric 1 [I-16.1.]: Percent of primary care visits at medical home Goal: 80% Data Source: Practice management system, EHR, or other documentation as designated by Performing Provider Milestone 13 Estimated incentive payment: $1,183,023</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### UT Health Regional Specialty Care Centers

**UTHealth, UTPhysicians**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Option 2.1.3</th>
<th>2.1.3 (A-F)</th>
<th>UT Health Regional Specialty Care Centers</th>
</tr>
</thead>
</table>
| 111810101.2.1                         | 111810101.3.16 | IT-6.1 (1) | **Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone measure)**  
Diabetes care: HbA1c poor control (>9.0%)  
NQF 0059 (Standalone measure) |

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proactive panel management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 4</strong> [P-4.]: Develop staffing plan to expand primary care team roles; Expand and redefine the roles and responsibilities of primary care team members.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Metric 1** [P-4.1.]: Expanded primary care team member roles  
Goal: 2 physicians, 6 community healthworkers, 2 nurse case managers, 2 social workers and 4 support staff, IT data analyst.  
Data Source: Revised job descriptions |                                 |                                 |                                 |
| Milestone 4 Estimated incentive payment: $790,222 | Year 3 Estimated Milestone Bundle Amount: $3,564,914 | Year 4 Estimated Milestone Bundle Amount: $3,707,510 | Year 5 Estimated Milestone Bundle Amount: $3,549,069 |
| Year 2 Estimated Milestone Bundle Amount: $3,160,890 |                                 |                                 |                                 |

**Total Estimated Incentive Payments for 4-Year Period:** $13,982,383
Project Option 2.2.1- 2.2 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System of Harris Health to Coordinate Care for Patients with Chronic Diseases

Unique RHP Project ID: 111810101.2.2
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider: UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s): The outpatient delivery system of UT Physicians will be redesigned to coordinate care for patients with chronic diseases (asthma, CHF, COPD, diabetes, and hypertension), based on Wagner's chronic care model and using evidence-based standards of care for each of the targeted diseases.

Need for the project: There are high rates of chronic diseases in our population. Because chronic care requires ongoing interaction between patients and the health system, there often arises challenges in care coordination. The evidence-based Chronic Care Model summarizes the basic elements for improving care of chronic disease patients, and there is need to apply such a model, if care outcomes are to be improved for patients with these conditions.

Target Population: This project targets people in our service area with diabetes, hypertension, asthma, COPD, or CHF. Patients of lower socioeconomic status (which number approximately 448,583 for the UTP clinics service areas) are known to have worse disease control due to the inability to maintain compliance in the long run, hence this project will be beneficial to the Medicaid population in the UTP clinics service areas.

Category 1 or 2 expected patient benefits:
Our goals are to increase the number of additional patients receiving care under the Chronic Care Model for Asthma, COPD, CHF, Diabetes, and Hypertension, and to improve the percentage of patients with targeted chronic diseases that have self-management goals. We expect to successfully provide coordinated care for a total of 81,000 patient visits, with at least 18,630 of these visits from patients on Medicaid. This is not inclusive of the additional patient encounters resulting from the involvement of the care team, which would easily be an additional 81,000 encounters.

Category 3 outcomes:
IT-2.1.1 Our goal is to reduce the admissions rate for Ambulatory Care Sensitive Conditions (including Chronic obstructive pulmonary diseases, Asthma, Heart failure, Hypertension, and Diabetes).
Project Option 2.2.1 – Expand Chronic Care Management Models: Redesign the Outpatient Delivery System of UT Physicians to Coordinate Care for Patients with Chronic Diseases

**Unique RHP Project Identification Number:** 111810101.2.2  
**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Project Description:** 2.2 Expand Chronic Care Management Models (Option 2.2.1)

Almost half of all Americans live with a chronic condition, and almost half of all people with chronic illness have multiple conditions. This also the situation in our region, as our community needs assessment shows that there are high rates of chronic diseases in our population, including asthma, CHF, COPD, diabetes, and hypertension. Because chronic care requires ongoing interaction between patients and the health system, there often arises challenges in care coordination. The evidence-based Chronic Care Model (Coleman et al. Evidence On The Chronic Care Model In The New Millennium, Health Affairs 28, no. 1 (2009): 75–85; 10.1377/hlthaff.28.1.75), summarizes the basic elements for improving care of chronic disease patients, and there is need to apply such a model, if care outcomes are to be improved for patients with these conditions.

The outpatient delivery system of UT Physicians will be redesigned to coordinate care for patients with chronic diseases (asthma, CHF, COPD, diabetes, and hypertension), based on Wagner's chronic care model (CCM) and using evidence-based standards of care as follows: The National Asthma Education and Prevention Program Expert Panel Report 3 guidelines, The National Institute for Clinical Excellence (NICE) COPD clinical guidelines, The Heart Failure Model of Care guidelines, The American Diabetes Association (ADA) Standards of Medical Care in Diabetes, and the JNCVII guidelines for hypertension. Wagner’s CCM identifies the essential elements of a health care system that encourage high-quality chronic disease care; these are self-management support, delivery system design, decision support, clinical information systems, and identification of complementary resources in the community. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. Reforms to be implemented using this model include: designing and implementing care teams (including non-physician health professionals) that are tailored to the patient’s health care needs, scheduling of next appointment before patient leaves office, use of appointment reminders, follow up of patients who missed appointments, regular review of all medications from all sources, ensuring patients can access their care teams by phone or email as well as access their medical information through an electronic patient portal, and referral of selected patients for more intensive counseling. Also, regular disease self-management education and support sessions will be provided free of charge to UT Physicians’ patients, and this will be tailored to the literacy levels and cultures of the patients.

Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.
Goal and Relationship to Regional Goals:

Project Goal: To develop and implement chronic disease management interventions that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute, emergency and inpatient care utilization.

This project addresses the following regional goal:

The implementation of the chronic care management model will ensure better outcomes for patients with chronic diseases, which is in line with the regional goal to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system."

Challenges:

Need: 1) High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease. 2) Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs.

Implementation: 1) Willingness of physicians to transit to a 'team-based' model of care that gives greater roles to other providers. 2) Low health literacy levels and low economic resources can influence patients' ability to be effective partners in their own care.

With training on the chronic care model and its application to chronic care, physicians and other providers will be better motivated to work as a team to deliver proactive care that keeps chronic disease patients stable and without a need for urgent care. The care team will also be made up of support personnel that will provide education and other support services that will help to assist patients in overcoming barriers to their participation in self-care.

5-Year Expected Outcome for Provider and Patients:

Successful implementation of the chronic care model will lead to better monitoring by the patient's care team and increased patient engagement in self-care, thereby reducing the need for acute episodic care. In addition to benefiting the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base of UTP clinics, this model of chronic care management will be available to another estimated 80,000 patient visits (due to UTPs primary and specialty care expansion projects), most of which are expected to be Medicaid clients. This project will benefit all Medicaid and low-income clients in addressing many of the barriers encountered in being compliant with chronic disease management plans, facilitating better health outcomes. Improved patient compliance is expected to produce a decrease in hospitalization for the ambulatory care sensitive chronic diseases targeted.

We expect to successfully provide coordinated care to 4,500 patients in DY4 and an additional 4,500 patients in DY5. Patients with chronic diseases typically see their provider much more frequently, such as diabetics who see their physician an average of 6 times per year,¹

which means that in DY4, we will have completed approximately 27,000 patient visits and by 
DY5, we will have completed approximately 54,000 visits for a total of \textbf{81,000} patient visits. At 
UT Physicians current payer mix of 23% Medicaid, approximately \textbf{18,630} of these visits would 
be from patients on Medicaid. We must note that this is a very conservative estimate, since we 
are expecting to increase our patient base as noted above and at a higher rate of patients on 
Medicaid, or Medicaid-eligible. It should also be noted that these patient visits are not inclusive 
of the additional patient encounters resulting from the involvement of the care team, which 
would easily be an additional 81,000 encounters.

\textbf{Starting Point/Baseline:} 
This is a new program. Consequently our baseline is zero. The targets for our milestones and 
metrics are based upon the current number of unique patients with a diagnosis of asthma, 
hypertension, diabetes, CHF, or COPD, which is 12,879.

\textbf{Rationale:} 
Asthma is increasing every year in the US; the proportion of people with asthma in the 
United States grew by nearly 15\% in the last decade. There are significant disparities in asthma 
prevalence in the US. Adults with an annual household income of $75,000 or less are more likely 
to have asthma than adults with higher incomes. (Asthma’s Impact on the Nation: Data from the 
CDC National Asthma Control Program. Available at: http://www.cdc.gov/asthma/ 
impacts_nation/AsthmaFactSheet.pdf. Accessed 10/15/12). People with asthma can often prevent 
asthma attacks if they are taught to use inhaled corticosteroids and other long-term control 
medicines correctly and to avoid asthma triggers. In 2008 less than half of people with asthma 
reported being taught how to avoid triggers. (CDC 2011: Asthma in the US. Available at:
http://www.cdc.gov/vitalsigns/Asthma/#. Accessed 10/15/12).

Chronic lower respiratory diseases, primarily COPD, are the third leading cause of death in the 
United States, and 5.1\% of U.S. adults report a diagnosis of emphysema or chronic bronchitis 
(Morbidity and Mortality Weekly Report (MMWR) March 2, 2012 / 61(08);143-146. Available 
at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6108a3.htm?s_cid=mm6108a3_w. 
Accessed 10/15/12). Excess health-care expenditures are estimated at nearly $6,000 annually for 
every COPD patient in the United States (Deaths from Chronic Obstructive Pulmonary Disease - 
United States, 2000--2005. November 14, 2008 / 57(45);1229-1232. Available at: 
Uncontrolled COPD leads to deterioration in lung function and eventually death.

Around 5.8 million people in the United States have heart failure and about 670,000 people 
are diagnosed with it each year. About one in five people who have heart failure die within one 
year from diagnosis but early diagnosis and treatment can improve quality of life and life 
expectancy for people who have heart failure. Heart failure results in significant costs to the 
system; it cost the US nearly $40 billion in 2010 (CDC 2010: heart failure facts. Available at: 
10/15/12).

Uncontrolled diabetes can result in complications with dire consequences for the patient. For 
example, the risk of stroke is 2 - 4 times higher among people with diabetes; diabetes is the 
leading cause of new onset blindness among adults aged 20 - 74 years in the US; nearly half of 
all cases of kindey failure can be attributed to diabetes; and more than half of all caes of 
nontraumatic lower limb amputations are because of poorly controlled diabetes. Diabetes also
predisposes patients to dental diseases, pregnancy complications, among other problems. Studies in the United States have shown that improved glycemic control benefits people with either type 1 or type 2 diabetes. In general, every percentage point drop in HbA1c blood test results (e.g., from 8.0% to 7.0%) can reduce the risk of microvascular complications (eye, kidney, and nerve diseases) by 40%.

In 2009-2010, the age-adjusted percentage of US adults with hypertension whose blood pressure was controlled was 53.3%. Hypertension is a leading cause of stroke, coronary artery disease, heart attack, and heart and kidney failure in the United States, all of which contribute to the rising costs of health care. Aggressive treatment of hypertension significantly decreases the risk of coronary artery disease, congestive heart failure, stroke, and resulting disability. Low-income individuals without prescription drug coverage are significantly more likely to skip doses to save money or make their hypertension medication prescriptions last longer. (Rein DB, Constantine RT, Orenstein D, Chen H, Jones P, Brownstein JN, et al. A cost evaluation of the Georgia Stroke and Heart Attack Prevention Program. Prev Chronic Dis [serial online] 2006 Jan [date cited]. Available from: URL: http://www.cdc.gov/pcd/issues/2006/jan/05_0143.htm. Accessed on 10/15/12).

**Project Components:**
Through the Redesign the Outpatient Delivery System of Harris Health to Coordinate Care for Patients with Chronic Diseases Program, we propose to meet all required project components listed below.

a) UTP will design and implement care teams that are tailored to the health care needs of patients with asthma, COPD, CHF, diabetes, and hypertension.
b) UTP care teams will include non-physician health professionals, such as pharmacists, case managers, nutritionists, health educators, and health coaches.
c) In addition to accessing their care team by appointment, patients will have 24/7 continuous access to their care teams wherever possible via expanded access points such as open scheduling, the nurse advise line, the online patient portal, and email.
d) Patient engagement will be further increased through patient education, group visits, self-management support, and coordination with community resources. UTP will empower patients to make lifestyle changes to stay healthy and manage their chronic conditions.
e) UTP’s quality improvement office will conduct QI for each of the clinics providing specialty care using methods such as rapid cycle improvement.
f) UTP will monitor project impacts and identify opportunities to expand the project to broader patient populations, including safety-net populations.

**Milestone and Metrics:**
For the Redesign the Outpatient Delivery System of Harris Health to Coordinate Care for Patients with Chronic Diseases Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

**Process Milestones and Metrics:**

**Milestone 1** [P-X1.]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign.
Metric 1 [P-X1.1.]: Implementation plan (eligibility criteria, implementation components, responsibilities, and timeline).

**Milestone 2 [P-X2.]:** Designate/hire personnel or teams to support and/or manage the project/intervention

Metric 1 [P-X2.1.]: Project managers, personnel assigned to teams, and team responsibilities.

**Milestone 3 [P-2.]:** Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care for Asthma, COPD, CHF, Diabetes, and Hypertension.

Metric 1 [P-2.1.]: Increase percent of staff trained

**Milestone 4 [P-4.]:** Formalize multi-disciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model.

Metric 1 [P-4.1.]: Increase the number of multi-disciplinary teams (e.g., teams may include physicians, mid-level practitioners, dieticians, licensed clinical social workers, psychiatrists, and other providers) or number of clinic sites with formalized teams.

**Milestone 5 [P-3.]:** Develop a comprehensive care management program for asthma, COPD, CHF, Diabetes, and Hypertension.

Metric 1 [P-3.1.]: Documentation of care management program. The Wagner Chronic Care Model will be utilized in program development.

**Milestone 6 [P-1.]:** Expand the Chronic Care Model to primary care clinics

Metric 1 [P-4.1.]: Increase number of primary care clinics using the Chronic Care model.

**Improvement Milestones and Metrics:**

**Milestone 7 [I-17.]:** Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally.

Metric 1 [I-17.1.]: X additional patients over baseline receive care under the Chronic Care Model for asthma, diabetes, hypertension, COPD, and CHF.

**Milestone 8 [I-17.]:** Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally.

Metric 1 [I-17.1.]: X additional patients over previous reporting period receive care under the Chronic Care Model for asthma, diabetes, hypertension, COPD, and CHF.

**Milestone 9 [I-18.]:** Improve the percentage of patients with targeted chronic diseases that have self-management goals.

Metric 1 [I-18.1.]: Patients with targeted chronic diseases with self-management goals.

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

This project addresses community needs CN.11 (High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease) and CN.20 (Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs).

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

This project represents a new initiative. UT Physicians proposes to provide chronic care management to its patients with chronic diseases, based upon Wagner's Chronic Care Model, which is a comprehensive, pro-active, patient-centered model of care.
Related Category 3 Outcome Measure(s):
OD-2 Potentially Preventable Admissions
  • IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate: (Standalone measure)
    Numerator: Total number of acute care hospitalizations for ambulatory care sensitive
conditions under age 75 years (including Chronic obstructive pulmonary diseases, Asthma, Heart
failure, Hypertension, and Diabetes). Exclusions: Individuals 75 years of age and older, or death
before discharge. Denominator: Total mid-year population under age 75

Relationship to other Projects:
1.1 (C3) - Expanded capacity in primary care will ensure the availability of staff to implement
the expansion of the chronic care management model for patients with asthma.
1.2 (A2, SPH1) - Part of the innovative training of primary care providers will be centered on
the chronic care model with emphasis on team-based practice.
1.3 (C12) - The disease management registry (Information Technology support) is a very
important component of Wagner's Chronic Care Model.
1.7 (A1) - Telemedicine will help to ensure that chronic care patients will get specialist input into
their care when and where needed.
1.9 (C4) - Also, the expansion of specialty care in the primary care setting will help to ensure
that chronic care patients will get specialist input into their care when and where needed.
1.10 (MS1) - The QI project will aid in the adoption of a 'whole systems' approach to chronic
management, enabling the implementation of a comprehensive and proactive approach to
chronic care in which the patient is kept in continuous contact with the care team.
2.1 (C1) - The expansion of chronic care management models will ensure more effective care for
patients enrolled in UT Medical Homes.

Relationship to Other Performing Providers’ Projects in the RHP:
Healthcare costs are significantly increased within a patient base with such aggressive
chronic conditions that have gone untreated. The initiatives focused to chronic disease
management focus to conditions such as asthma, hypertension, and diabetes and are similar in
the approach of managing & proactively treating chronic conditions in order to reduce 30-day
readmission rates, inappropriate emergency department utilization, and healthcare costs. The
Region 3 Initiative grid allows a cross reference of initiatives associated with chronic disease
management. (addendum)

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

Project Valuation:
The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be
used to rate each project on a 10-point scale. The ratings for each criteria were weighted,
summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. **Transformational Impact** (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. **Population Served/Project Size** (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.

3. **Aligned with Community Needs** (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. **Cost Avoidance** (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects.

5. **Partnership/Collaboration** (Weight = 10%): *This was not rated*, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. **Sustainability** (Weight = 15%): *This was also not rated*, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>IT-2.11</th>
<th>Ambulatory Care Sensitive Conditions Admissions Rate: (Standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 1</strong> [P-X1.]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-X1.1]: Implementation plan (eligibility criteria, implementation components, responsibilities, and timeline). Baseline/Goal: Our current practice does not apply comprehensive care coordination processes to chronic disease management. The goal is to develop and document a specific plan to make the transition from usual care to coordinated care. Data Source: Program materials</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 1 Estimated incentive payment:</strong> $ 1,293,092</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-X2.]: Designate/hire personnel or teams to support and/or manage the project/intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-X2.1.]: Project managers, personnel assigned to teams, and team responsibilities. Baseline: 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3</strong> [P-2.]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care for Asthma, COPD, CHF, Diabetes, and Hypertension.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-2.1.]: Increase percent of staff trained. Baseline/Goal: All staff in the 4 community clinics Data Source: HR, training program materials</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3 Estimated incentive payment:</strong> $ 972,250</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 4</strong> [P-4.]: Formalize multi-disciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-4.1.]: Increase the number of multi-disciplinary teams (e.g., teams may include physicians, mid-level practitioners, dieticians, licensed clinical social workers, psychiatrists, and other providers) or number of clinic sites with formalized teams. Baseline: 0 (new program)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 6</strong> [P-1.]: Expand the Chronic Care Model to primary care clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-4.1.]: Increase number of primary care clinics using the Chronic Care Model. Baseline/Goal: The baseline is zero, since this is a new program. The goal will be to implement the model in 4 UTP clinics. Data Source: Documentation of practice management.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 6 Estimated incentive payment:</strong> $ 1,516,709</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 7</strong> [I-17.]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [I-17.1.]: X additional patients receive care under the Chronic Care Model for hypertension, asthma, diabetes, COPD, and CHF. Goal: 4,500 Data Source: Registry</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 7 Estimated incentive payment:</strong> $ 1,451,892</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 8</strong> [I-17.]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [I-17.1.]: X additional patients receive care under the Chronic Care Model for hypertension, asthma, diabetes, COPD, and CHF. Goal: 4,500 Data Source: Registry</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 8 Estimated incentive payment:</strong> $ 1,451,892</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 9</strong> [I-18.]: Improve the percentage of patients with targeted chronic diseases that have self-management goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [I-18.1.]: Patients with targeted chronic diseases with self-management goals. Goal: 60% Data Source: Registry</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 9 Estimated incentive payment:</strong> 1,451,892</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**OPTION 2.2.1**

**REDESIGN THE OUTPATIENT DELIVERY SYSTEM OF HARRIS HEALTH TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>111810101.3.18</th>
<th>IT-2.11</th>
<th>Ambulatory Care Sensitive Conditions Admissions Rate: (Standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: 2 project managers, 4 clinical leaders, 1 trainer, additional team members designated by the project managers and team leaders. Data Source: Program documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 2 Estimated incentive payment: $ 1,293,091</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Multidiciplinary teams will be built around the 5 chronic disease states targeted (asthma, diabetes, hypertension, CHF, COPD) at each of the 4 community clinics Data Source: Project documentation, team rosters, team-member roles.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 4 Estimated incentive payment: $ 972,249</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5 [P-3.]:</strong> Develop a comprehensive care management program for asthma, diabetes, hypertension, CHF, and COPD.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1 [P-3.1.]:</strong> Documentation of Care management program. The Wagner Chronic Care Model will be utilized in program development. Baseline/Goal: Our current practice does not apply comprehensive care coordination processes to chroinc disease management. The goal is to develop, document, and implement a program based on the based on the evidence-based and increasingly used Wagner’s chronic care model for the 5 targeted disease states (asthma, diabetes, hypertension, CHF, and COPD) Data Source: Program materials</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>111810101.2.2</td>
<td>OPTION 2.2.1</td>
<td>2.2.1 (A-E)</td>
<td>REDesign the OUTPATIENT DELIVERY SYSTEM OF HARRIS HEALTH to COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES</td>
</tr>
<tr>
<td>----------------</td>
<td>---------------</td>
<td>-----------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>UTHealth, UTPhysicians 111810101</td>
</tr>
<tr>
<td>Related Category 3</td>
<td>Outcome Measure(s):</td>
<td>111810101.3.18</td>
<td>IT-2.11</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Milestone 5 Estimated incentive payment: $972,249</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $2,586,183</td>
<td>Year 3 Estimated Milestone Bundle Amount: $2,916,748</td>
<td>Year 4 Estimated Milestone Bundle Amount: $3,033,417</td>
<td>Year 5 Estimated Milestone Bundle Amount: $2,903,784</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $11,440,132</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Project Option 2.9.1- 2.9 Establish/Expand a patient Care Navigation Program: UTHealth
Regional Patient Navigation

Unique RHP Project ID: 111810101.2.3
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider: UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s): This project targets patients at high risk of disconnect from institutionalized health care; specifically, patients that entered Memorial Hermann Hospital-TMC through the emergency department (ED). Care navigators will support these patients to navigate through the continuum of health care services, ensuring that patients receive coordinated, timely, and site-appropriate health care services.

Need for the project: Our region has high rates of inappropriate use of the ED and there is a lack of patient navigation, patient and family education and information programs. Frequent ED users do so for various reasons that often include inability to afford care, lack of knowledge on how to navigate the health care system, poor access to good quality primary care, and so on. Care navigators can help patients and their families navigate the fragmented maze of doctors’ offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system.

Target Population: In-Patient admissions at Memorial Hermann Hospital-TMC without a primary care physician.

Category 1 or 2 expected patient benefits:
Based on the capacity we will be providing for navigation services, we estimate that there will be over 12,480 patient encounters made by the navigators each year, for a total of over 37,000 patient encounters by DY5, with at least 6,900 of these patients on Medicaid. By getting patients connected with a primary care provider who can assist them in managing their health, we expect better health outcomes and fewer hospitalizations.

Category 3 outcomes:
IT-3.9: Our goal is to reduce the percentage of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission.
Project Option 2.9.1 – Establish/Expand a Patient Care Navigation Program: UTHealth
Regional Patient Navigation

**Unique RHP Project Identification Number:** 111810101.2.3
**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Project Description:** 2.9 Establish/Expand a Patient Care Navigation Program: (Option 2.9.1)

A patient care navigation program will be designed and implemented within Memorial Hermann Hospital-TMC. The program will target patients at high risk of disconnect from institutionalized health care. Specifically, patients admitted to Memorial Hermann Hospital-TMC who do not have a primary care provider. Care navigators - community health workers (CHWs) - recruited and trained to deliver culturally competent care will work with UT Health Hospitalists to assist the patients in linking up with a primary care providers within UT Health medical homes and other appropriate sources of primary care. The patient navigators will help and support these patients in receiving continuity of care, ensuring that patients receive coordinated, timely, and site-appropriate health care services, by assisting in connecting patients to primary care physicians and/or medical home sites. This will complement the ED navigation program at Memorial Hermann Hospital-TMC, by ensuring that patients receive appropriate navigations services regardless of the type of encounter with hospital services.

Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.

**Goal and Relationship to Regional Goals:**

**Project Goal:**

Help and support patients especially in need of coordinated care navigate through the continuum of health care services so that patients can receive coordinated, timely services when needed with smooth transitions between health care settings.

This project addresses the following regional goal:

The care navigation project will make it easier for patients to access the right care in the right place, thereby attaining the regional goal to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services..."

**Challenges:**

- **Need:** 1) High rates of inappropriate emergency department utilization. 2) Lack of patient navigation, patient and family education and information programs.
- **Implementation:** 1) Access to Memorial Hermann Hospital ED data. 2) Recruitment and retention of care navigators.
UT Physicians have had good working relationship with the Memorial Hermann Hospital System and this project will enable further collaboration to tackle one of the greatest challenges of the US health care system - inappropriate emergency department use.

5-Year Expected Outcome for Provider and Patients:

We expect to achieve increased uptake of primary care services by people who tend to rely on the ED for their health care needs. In addition to benefiting the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base of UTP clinics, this project will specifically target patients at high risk of disconnect from institutionalized health care that enter the healthcare system via the Memorial Hermann Hospital ED. These patients are typically indigent individuals (Medicaid, or Medicaid-eligible) who need additional assistance in maintaining their health via ambulatory care settings. While we expect to see improved outcomes for these patients in a number of conditions, we will be measuring 30 day readmission rates for discharges with an index COPD admission.

We will be providing navigation services for patients without a primary care provider who are admitted to Memorial Hermann Hospital-TMC. Based on the capacity we will be providing for navigation services, we estimate that there will be over 12,480 patient encounters made by the navigators each year, for a total of over 37,000 patient encounters by DY5. Using a very conservative estimate, we expect at least 6,900 of these patients will be Medicaid, or Medicaid eligible.

Starting Point/Baseline:

This is a new program. The baseline for the number of patients without a primary care provider admitted to Memorial Hermann Hospital-TMC will be established during DY2. Targets are estimated based upon the capacity we will be providing for navigation services.

Rationale:

Our region has high rates of inappropriate use of the ED and potentially preventable re-admissions. Often this is because patients lack the knowledge on how to navigate the health care system, have poor access to good quality primary care, and so on. Care navigators can help patients and their families navigate the fragmented maze of doctors’ offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system. There are different kinds of services that could be offered by navigators and this may include: setting up contacts with primary care, facilitating communication among patients, family members and healthcare providers, coordinating care among providers, arranging financial support and assisting with paperwork, and facilitating follow-up appointments.

Community health workers have close ties to the local community and serve as important links between underserved communities and the healthcare system, hence they will amke excellent care navigators. They also possess the linguistic and cultural skills needed to connect with patients from underserved communities.

Project Components:

Through the UTHealth Regional Patient Navigation Program, we propose to meet all required project components listed below.
a) UTP will work with Memorial Hermann Hospital (MHH) and the UT School of Public Health to conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program (frequent ED users, including those at risk of disconnect from institutionalized ambulatory care). Those patient population(s) identified will be targeted for our preventable ED reduction program using trained health care navigators.

b) UTP will work with MHH to establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care.

c) UTP and MHH will collaborate to provide appropriate training for navigators, which will include case managers/workers, community health workers, and other types of health professionals.

d) Navigators will be deployed to connect patients to primary and preventive care in the UT Physicians medical homes, or the Memorial Hermann Medical Group’s pediatric practices (staffed and managed by UT Physicians) to increase access to care management, including education in chronic disease self-management.

e) UTP’s quality improvement office will conduct QI for each of the clinics providing specialty care using methods such as rapid cycle improvement.

Milestones and Metrics:

For the UTHealth Regional Patient Navigation Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

**Milestone 1 [P-1.]:** Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program.

Metric 1 [P-1.1.]: Provide report identifying the following:

- Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy).
- Gaps in services and service needs.
- How program will identify, triage and manage target population (i.e. Policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts).
- Ideal number of patients targeted for enrollment in the patient navigation program
- Number of Patient Navigators needed to be hired
- Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients

**Milestone 2 [P-X1]:** Establish a baseline

Metric 1 [P-X1.1.]: Establish a baseline for the average number of patients admitted to Memorial Hermann Hospital-TMC that do not have a primary care provider.

**Milestone 3 [P-X2]:** Complete a planning process/submit a plan in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign
Metric 1 [P-X2.1.]: Complete an implementation plan and protocols to ensure that patients admitted to Memorial Hermann Hospital-TMC without a primary care provider are provided with navigation services and given an appointment before leaving the hospital.

**Milestone 4 [P-2.]:** Expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education.

Metric 1 [P-2.1.]: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators.

**Milestone 5 [P-8.]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

Metric 1 [P-8.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Milestone 7 [P-3.]:** Provide care management/navigation services to targeted patients.

Metric 1 [P-3.1.]: Increase in the number or percent of targeted patients enrolled in the Program.

**Milestone 8 [P-8.]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

Metric 1 [P-8.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Milestone 10 [P-5.]:** Execution of evaluation process for project innovation.

Metric 1 [P-5.1.]: Document evaluative process, tools and analytics.

**Milestone 11 [P-8.]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

Metric 1 [P-8.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Improvement Milestones and Metrics:**

**Milestone 6 [I-6.]:** Increase number of PCP referrals for patients without a medical home who use hospital services.

Metric 1 [I-6.4.]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment (DY3).

**Milestone 9 [I-6.]:** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services.

Metric 1 [I-6.4.]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment (DY4).

**Milestone 12 [I-6.]:** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services.

Metric 1 [I-6.4.]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment (DY5).

**Unique community need identification numbers the project addresses:**
This project addresses community needs CN.8 (High rates of inappropriate emergency department utilization) and CN.23 (Lack of patient navigation, patient and family education and information programs).

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**
This project represents a new initiative. This program does not currently exist in the UT Physicians and Memorial Hermann Hospital-TMC system. This project proposes to target patients at high risk of disconnect from institutionalized health care with an intervention for getting them into primary care settings, where they can receive regularized care and avoid the need for episodic acute care.

**Related Category 3 Outcome Measure(s):**
OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs )
- IT-3.9 Chronic Obstructive Pulmonary Disease 30 day readmission rate (Standalone measure)

Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of COPD and with a complete claims history for the 12 months prior to admission.

**Relationship to other Projects:**
1.1 (C3) - Expanded primary care services will ensure there is reserve capacity to handle the increased demand anticipated by the successful diversion of nonurgent care from the Emergency Department to primary care settings.
1.2 (A2, SPH1) - The SPH1 project will ensure their is sufficient supply of CHWs to serve as care navigators and the training received by residents (A2) will help the physicians understand how to integrate CHWs as members of the health care team.
1.3 (C12) - The disease management registry will enable the identification of patients who default from care so that they can be actively sought and brought into compliance, which will help to reduce frequent ED use.
1.6 (C11) - Navigators will be a resource available to the nurse triage line to help ensure patients get the right care at the right time and in the right setting.
1.9 (C4) - The expansion of specialty care in the primary care setting will help patient navigators ensure that patients get appropriate specialist input into their care when and where needed.
2.1 (C1-2) - Care navigators will assist frequent ED users in getting enrolled with a primary care team at UT Medical Homes, which will aid in reducing inappropriate ED use.
2.2 (C5-9,CL3) - Getting frequent ED users enrolled in a UT Medical Home, where they can receive guidance and regular evidence-based care for chronic diseases will reduce the need for acute care services being received in the ED.

**Relationship to Other Performing Providers’ Projects in the RHP:**
The ability to properly identify and monitor specific patients with chronic conditions or frequent emergency department utilization trends will allow the region to accurately manage the
Plan for Learning Collaborative:
UTHHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

Project Valuation:
The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects.

5. Partnership/Collaboration (Weight = 10%): This was not rated, because UTHHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): This was also not rated, because UTHHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
### Related Category 3 Outcome Measure(s):

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 1 [P-1.1]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program.</td>
<td><strong>Milestone 4</strong> [P-2.]: Establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including programs to train the navigators, develop procedures and establish continuing navigator education.</td>
<td><strong>Milestone 7</strong> [P-3.]: Provide care management/navigation services to targeted patients.</td>
<td><strong>Milestone 10</strong> [P-5.]: Execution of evaluation process for project innovation.</td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-1.1.]: Provide report identifying the following: Targeted patient population characteristic, Gaps in services and service needs, how program will identify, triage &amp; manage target pop'n, ideal number targeted for enrollment, number of navigators needed, available site, state, county, and clinical data. Baseline/Goal: Conduct and provide needs assessment per the above description. Data Source: Program documentation, EHR, claims, needs assessment survey.</td>
<td><strong>Metric 1</strong> [P-2.1.]: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators. Baseline: 0 Goal: 12 Navigators and 2 social workers Data Source: Program records, training records, policies and procedures.</td>
<td><strong>Metric 1</strong> [P-3.1.]: Increase in the number or percent of targeted patients enrolled in the program Baseline: To be established in DY2. However, we expect to have the capacity to handle 23,040 patients per year. Goal: Provide navigation services to targeted patients and enroll 20% over baseline of patients without PCP Data Source: Enrollment reports.</td>
<td><strong>Metric 1</strong> [P-5.1.]: Document evaluative process, tools and analytics. Baseline/Goal: Conduct and document evaluation processes, tools, and analytics Data Source: Performing Provider contract or other documentation of implementation by Performing Provider. Milestone 10 Estimated incentive payment: $ 1,075,476.</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 1</strong> Estimated incentive payment: $ 957,845</td>
<td><strong>Milestone 4</strong> Estimated incentive payment: $ 1,080,277</td>
<td><strong>Milestone 7</strong> Estimated incentive payment: $ 1,123,488</td>
<td><strong>Milestone 10</strong> Estimated incentive payment: $ 1,075,476.</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-X1]: Establish a baseline</td>
<td><strong>Milestone 5</strong> [P-8.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-8.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Attend 2 meetings per year Data Source: Documentation of semiannual meetings including</td>
<td><strong>Milestone 8</strong> [P-8.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-8.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Attend 2 meetings per year Data Source: Documentation of semiannual meetings including</td>
<td><strong>Milestone 11</strong> [P-8.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-8.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Attend 2 meetings per year Data Source: Documentation of semiannual meetings including</td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td>111810101.3.19</td>
<td>IT-3.9</td>
<td>Chronic Obstructive Pulmonary Disease 30 day readmission rate (Standalone measure)</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------</td>
<td>-------</td>
<td>--------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Hospital EMR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 2 Estimated incentive payment: $ 957,845</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3</strong> [P-X2]: Complete a planning process/submit a plan in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-X2.1]: Complete an implementation plan and protocols to ensure that patients admitted to Memorial Hermann Hospital-TMC without a primary care provider are provided with navigation services and given an appointment before leaving the hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Draft and complete protocols and implementation plan. Obtain appropriate approvals</td>
<td>Baseline/Goal: Attend at least 2 meetings a year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Project documents and approved policies</td>
<td>Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 3 Estimated incentive payment: $ 957,845</td>
<td>Milestone 5 Estimated incentive payment: $ 1,080,277</td>
<td>Milestone 8 Estimated incentive payment: $ 1,123,488</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Attend at least 2 meetings a year</td>
<td>semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>Milestone 11 Estimated incentive payment: $ 1,075,476</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Hospital EMR</td>
<td>Milestone 9 [I-6.]: Increase number of PCP referrals for patients without a medical home who use hospital services.</td>
<td>Milestone 12 [I-6.]: Increase number of PCP referrals for patients without a medical home who use hospital services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 6</strong> [I-6.]: Increase number of PCP referrals for patients without a medical home who use hospital services.</td>
<td><strong>Metric 1</strong> [I-6.4.]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment Goal: During DY3, Navigators will schedule primary care appointments for 20% of patients without a primary care provider who are discharged from Memorial Hermann Hospital-TMC. Based on estimated capacity, this would be approximately 2,250. Data Source: Performing Provider administrative data on patient</td>
<td><strong>Metric 1</strong> [I-6.4.]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment Goal: During DY4, Navigators will schedule primary care appointments for 30% of patients without a primary care provider who are discharged from Memorial Hermann Hospital-TMC. Based on estimated capacity, this would be approximately 3,750. Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Draft and complete protocols and implementation plan. Obtain appropriate approvals</td>
<td>Baseline: 0 (new program). However, we expect to be able to handle 12,480 patient encounters per year Goal: During DY3, Navigators will schedule primary care appointments for 20% of patients without a primary care provider who are discharged from Memorial Hermann Hospital-TMC. Based on estimated capacity, this would be approximately 2,250. Data Source: Performing Provider administrative data on patient</td>
<td>Milestone 9 Estimated incentive payment: $ 1,123,488</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Project documents and approved policies</td>
<td>Milestone 5 Estimated incentive payment: $ 1,080,277</td>
<td>Milestone 8 Estimated incentive payment: $ 1,123,488</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 3 Estimated incentive payment: $ 957,845</td>
<td>Milestone 9 Estimated incentive payment: $ 1,123,488</td>
<td>Milestone 12 Estimated incentive payment: $ 1,075,475</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>Milestone 11 Estimated incentive payment: $ 1,075,476</td>
<td>Milestone 12 Estimated incentive payment: $ 1,075,475</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Related Category 3 Outcome Measure(s):

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

- **Chronic Obstructive Pulmonary Disease 30 day readmission rate (Standalone measure)**
- ** encounters and scheduling records from patient navigator program.**
- **Milestone 6 Estimated incentive payment: $1,080,277**

**Year 2 Estimated Milestone Bundle Amount:** $2,873,536  
**Year 3 Estimated Milestone Bundle Amount:** $3,240,831  
**Year 4 Estimated Milestone Bundle Amount:** $3,370,464  
**Year 5 Estimated Milestone Bundle Amount:** $3,226,427

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $12,711,258

---

Regional Healthcare Partnership Plan  
Region 3  
1549
Project Option 2.10.1- 2.10 Use of Palliative Care Programs: Integrating Palliative Care into Critical Care

**Unique RHP Project ID:** 111810101.2.4  
**Performing Provider Name/TPI:** UTHealth, UTPhysicians / 111810101

**Project Summary:**

Provider: UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

**Intervention(s):** Patients admitted to any adult ICU at Memorial Herman Hospital-TMC who are at high risk of death in or soon after hospitalization will receive a palliative care consultation to supplement their clinical therapy and assist in determination of goals of care which may include transitioning the patients from acute hospital care into home care, hospice or a skilled nursing facility.

**Need for the project:** While end-of-life care was once associated almost exclusively with terminal cancer, today there is need for end-of-life care for a number of other conditions, such as congestive heart failure. In addition to providing improved care and comfort for dying patients and their families, palliative care programs have been shown to provide considerable cost savings.

**Target Population:** Patients admitted to any adult ICU at Memorial Herman Hospital-TMC who are at high risk of death in or soon after hospitalization.

**Category 1 or 2 expected patient benefits:**
Increased uptake of palliative care services, greater involvement of patients and/or their families in end-of-life decisions, and increased satisfaction with end-of-life care. Palliative care services will be available to the Medicaid and Medicaid-eligible populations receiving care at Memorial Hermann Hospital that meet the intervention criteria. With this project, we will have the capacity to deliver approximately **9,288** additional palliative care consults and accomplish an additional **4,848** transitions by the end of DY5.

**Category 3 outcomes:**
Our goals are to increase the number of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter (IT-13.1), increase the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments (IT-13.2), and to increase the percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a
discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss (IT-13.5).
Project Option 2.10.1 – Use of Palliative Care Programs: Integrating Palliative Care into Critical Care

**Unique RHP Project Identification Number:** 111810101.2.4  
**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Project Description:** 2.10 Use of Palliative Care Programs (Option 2.10.1)

The project will entail identifying patients admitted to any adult ICU at Memorial Herman Hospital-TMC who are at high risk of death in or soon after hospitalization. Patients will be screened based on meeting one or more of the following criteria: severe life-threatening acute illness, progressive terminal illness, significant exacerbation of chronic debilitating illness, or declining quality of life and independent functioning in the past 6 months. In collaboration with the primary clinical team, these patients will receive a palliative care consultation to supplement their clinical therapy and assist in determination of goals of care which may include transitioning the patients from acute hospital care into home care, hospice or a skilled nursing facility. Patient/family experience surveys regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care will also be implemented.

UTHealth will recruit additional physicians trained in palliative care and other team staff to expand the existing palliative care program. The current partnership of UTHealth and Memorial Hermann Hospital-TMC has been a successful program, which is seeing increased demand and needs further expansion. Since the start of the program in 2004, over 1,000 patients have received palliative care related to cancer, heart failure, and various other illnesses, including infants in the NICU. In 2010, palliative care was provided to 84 cancer patients, 467 non-cancer patients, and 25 patients for whom the illness is unknown. In 2011, 203 patients with heart failure (DRGS 291, 292, 293) received palliative care. (Data from the UTHealth Medical School, Geriatric & Palliative Medicine Division, Palliative Fact Sheet August 2012.)

Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.

**Goal and Relationship to Regional Goals:**

**Project Goal:**

Patients receive dignified and culturally appropriate end-of-life care, which is provided for patients with terminal illnesses in a manner that prioritizes pain control, social and spiritual care, and patient/family preferences.

**This project addresses the following regional goal:**

One of the goals of the region is "to develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction". The palliative care project when successfully implemented will make the health system better suited to attend to patients' needs at the end-of-life thereby increasing satisfaction.
Challenges:
Need: 1) Education and information about the dying process and the various options for care. 2) Support and navigation in acting upon their preferences for care.
Implementation: 1) Staff recruitment and retention. 2) Willingness of patients, or their families, to embrace palliative care.

The project will mitigate the challenges patients and their families face due to lack of access to information to enable informed end-of-life decisions that are satisfactory. Gradually as the program gets established, the learning process will enable development of best practices in palliative care and increased likelihood of patients to embrace care options.

5-Year Expected Outcome for Provider and Patients:
Increased uptake of palliative care services, greater involvement of patients and/or their families in end-of-life decisions, and increased satisfaction with end-of-life care. These services will be available to the Medicaid and Medicaid-eligible populations receiving care at Memorial Hermann Hospital that meet the intervention criteria. With this project to expand palliative care consults and increase transitions into non-hospital settings, we will have the capacity to deliver approximately 9,288 additional palliative care consults and accomplish an additional 4,848 transitions by the end of DY5. We conservatively estimate that a minimum of 1,300 additional palliative care consults and an additional 679 transitions will have been accomplished for the Medicaid population.

Starting Point/Baseline:
Currently Memorial Hermann Hospital administers a Palliative program for some of their patients. Last year in 2012 they consulted with 1,166 patients and their families. Of those consults, 81% were with the adult population. The program is staffed with two physicians, three specialized nurse personnel (1 being the Director of the program) and an administrative assistant. They also have two volunteer physicians that help when time permits.

Rationale:
While end-of-life care was once associated almost exclusively with terminal cancer, today we are providing end-of-life care for a number of other conditions, such as congestive heart failure and infants and their families in the NICU. Our experience has shown that that palliative and hospice care could be more widely embraced for many dying patients. The goal of palliative medicine is to improve or maintain quality of life in patients with life-limiting or life-threatening diseases. Palliative medicine is a recognized medical subspecialty of both the American Board of Medical Specialties and American Osteopathic Association. Palliative medicine involves the control of symptoms associated with chronic disease such as nausea, pain and shortness of breath for example, as well as management of the symptoms that are part of the dying process. Along with symptom control, palliative medicine teams provide comfort, social and spiritual interventions for patients & their families. Palliative care, unlike hospice, is provided simultaneously with all other appropriate disease-directed treatments (Morrison RS, Meier DE. Clinical practice: palliative care. N Engl J Med. 2004;350(25): 2582-2590). Palliative medicine programs markedly reduce lengths of stay in hospitals on both wards and ICU settings. Data from the 2009 American Hospital Association Annual Survey showed that between 2000 and 2008, the number of hospitals with palliative medicine programs grew by 125.8% from 658 to 1486 (Center for the Advancement of Palliative Care. http://www.capc.org/news-and-

In addition to providing improved care and comfort for dying patients and their families, palliative care programs have been shown to provide considerable cost savings. According to a study of 5,354 subjects conducted by Morrison, et al. (Archives of Internal Medicine, 2008), palliative care teams saved $1,696 in direct costs per admission (P = .004) for patients discharged alive and $4,908 in direct costs per admission (P=.003) for patients who died. For a 400-bed hospital seeing 500 patients a year, this translates into a net savings of $1.3 million per year after adding physician revenues and subtracting personnel costs (Morrison RS, Penrod JD, Cassel JB, et al. Cost savings associated with United States hospital palliative care consultation programs. Arch Intern Med. 2008;168(16): 1783-1790). The palliative medicine service provided by UTHealth at Memorial Hermann Hospital-TMC has seen consistent growth in consult numbers since the program’s inception in 2004. For the 532 patients receiving care in 2008, we saw a median per person per day savings of $5,292 after the palliative care consult (with a reduction in the average length of stay from 9.5 to 2.3 days) and for the 698 patients receiving palliative care consults in 2009, we realized a median per person per day savings of $4,727 (with a reduction in the average length of stay from 8.5 to 2.5 days). (Data from white paper: CBDyer, MD, GVaras, DO, N Walter. Palliative Medicine: A Critical Component of Modern Health Care. April, 2010.)

Project Components:

Through the Integrating Palliative Care into Critical Care Program, we propose to meet all required project components listed below.

a) UTP will develop a business case for palliative care
b) UTP will conduct the necessary planning activities prior to implementing the expanded palliative care program.
c) UTP will recruit additional physicians to provide palliative care at MHH.
d) UT Palliative Care Physicians will deliver palliative care to those patients with terminal illness at MHH and transition patients from acute hospital care into home care, hospice, or a skilled nursing facility wherever possible.
e) UTP will conduct patient/family experience surveys regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care with the aim to use this information to improve scores over time.
f) UTP’s quality improvement office will conduct QI for each of the clinics providing specialty care using methods such as rapid cycle improvement.
Milestones and Metrics:
For the Integrating Palliative Care into Critical Care Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

**Milestone 1 [P-1.]:** Develop a hospital-specific business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program
Metric 1 [P-1.1.]: Business case

**Milestone 2 [P-5.]:** Expand a palliative care program
Metric 1 [P-5.1.]: Implement expanded comprehensive palliative care program

**Milestone 3 [P-6.]:** Increase the number of palliative care consults over baseline
Metric 1 [P-6.1.]: Palliative care consults meet targets established by the program

**Milestone 4 [P-11.]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.
Metric 1 [P-11.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Milestone 7 [P-8.]:** Document the conditions for which palliative care is consulted.
Metric 1 [P-8.1.]: Breadth of conditions for which palliative care is utilized.

Improvement Milestones and Metrics:

**Milestone 5 [I-12.]:** Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time
Metric 1 [I-12.1.]: Survey developed and implemented; scores increased over time

**Milestone 6 [I-9.]:** Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services.
Metric 1 [I-9.1.]: Transitions accomplished

**Milestone 8 [I-10.]:** Among patients who died in the hospital, increase the proportion of those who received a palliative care consult.
Metric 1 [I-10.1.]: Percent of total in-hospital deaths who had a palliative care consult.

Unique community need identification numbers the project addresses:
This project addresses community needs CN.7 (Insufficient access to care coordination practice management and integrated care treatment programs) and CN.23 (Lack of patient navigation, patient and family education and information programs).

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project represents an expansion of a currently existing program. This project proposes to expand palliative care services to patients beyond cancer, congestive heart failure, and infants and their families in the NICU, to any patients and their families admitted to any adult ICU.
Related Category 3 Outcome Measure(s):

OD-13 Palliative Care

- IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure)
  Increase the number of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.
  Exclusion: patients with length of stay < 1 day in palliative care or <7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

OD-13 Palliative Care

- IT-13.2 Treatment Preferences (NQF 1641) (Non-standalone measure)
  Percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments.
  Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice.

OD-13 Palliative Care

- IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone)
  Increase the number of patients discharged from hospice or palliative care with clinical record documentation of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period.

Relationship to other Projects:

1.9 (C4) - The disease management registry will serve as a useful resource to every provider, including palliative care providers, involved in caring for the enrolled patients.
2.11 (C10) - The medication management program will serve as a useful resource to palliative care providers, as they work to help the patient and their family achieve their care goals.

Relationship to Other Performing Providers’ Projects in the RHP:

The regional need for palliative care is that of upmost priority and is addressed in this initiative. This initiative is unique to Pass 1 initiatives and focuses to outcome measures of pain assessments, treatment preferences, and patients receiving hospice and palliative care. The Region 3 Initiative Grid (addendum) can provide a cross reference to all other initiatives.

Plan for Learning Collaborative:

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

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria and the reasons two of the criteria were not used:

1. **Transformational Impact** (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. **Population Served/Project Size** (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.

3. **Aligned with Community Needs** (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. **Cost Avoidance** (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects.

5. **Partnership/Collaboration** (Weight = 10%): *This was not rated*, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. **Sustainability** (Weight = 15%): *This was also not rated*, because UTHealth does not consider any of the projects to be unsustainable or at the very least do not consider one project less sustainable than another. Giving the projects the same or very similar ratings on these criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
<table>
<thead>
<tr>
<th>111810101.2.4</th>
<th>OPTION 2.10.1</th>
<th>2.10.1 (A-D)</th>
<th>MS3 INTEGRATING PALLIATIVE CARE INTO CRITICAL CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td>111810101.3.20</td>
<td>IT-13.1</td>
<td>Pain assessment (NQF-1637) (Non-standalone measure)</td>
</tr>
<tr>
<td></td>
<td>111810101.3.21</td>
<td>IT-13.2</td>
<td>Treatment Preferences (NQF 1641) (Non-standalone measure)</td>
</tr>
<tr>
<td></td>
<td>111810101.3.22</td>
<td>IT-13.5</td>
<td>Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1** [P-1.]: Develop a hospital-specific business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program

**Metric 1** [P-1.1.]: Business case
Baseline/Goal: Look at current model and organizational chart. Determine needs for the program and supporting business case
Data Source: Business case write-up; documentation of planning activities

**Milestone 1 Estimated incentive payment:** $ 742,331

**Milestone 2** [P-5.]: Expand a palliative care program

**Metric 1** [P-5.1.]: Implement expanded comprehensive palliative care program
Goal: Hire 2 FTE physicians; 2 Fellows; 2 Nurse Practitioners
Data Source: Palliative care program

**Milestone 3** [P-6.]: Increase the number of palliative care consults over baseline

**Metric 1** [P-6.1.]: Palliative care consults meet targets established by the program
Baseline: 1,166
Goal: Increase by 2,786
Data Source: EHR, palliative care database

**Milestone 3 Estimated incentive payment:** $ 837,215

**Milestone 4** [P-11.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

**Metric 1** [P-11.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.
Baseline/Goal: attend 2 meetings per year
Data Source: Documentation of

**Milestone 5** [I-12.]: Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time

**Metric 1** [I-12.1.]: Survey developed and implemented; scores increased over time
Baseline: In 2012, 529 surveys sent with a response rate of 14%. Overall rating was 74%
Goal: Increase response rate to 20% and Overall rating to 80%
Data Source: Memorial Hermann Patient/family experience survey

**Milestone 5 Estimated incentive payment:** $ 870,703

**Milestone 6** [I-9.]: Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services.

**Metric 1** [I-9.1.]: Transitions

**Milestone 7** [I-9.1.]: Transitions

**Milestone 7** [I-10.]: Among patients who died in the hospital, increase the proportion of those who received a palliative care consult.

**Metric 1** [I-10.1.]: Percent of total in-hospital deaths who had a palliative care consult
Baseline: 2012: Of 1,111 patients who died in the hospital, 23.49% received a palliative care consult.
Goal: Increase the percentage of
<table>
<thead>
<tr>
<th>111810101.2.4</th>
<th><strong>OPTION 2.10.1</strong></th>
<th>2.10.1 (A-D)</th>
<th><strong>MS3 INTEGRATING PALLIATIVE CARE INTO CRITICAL CARE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>UTHealth, UTPhysicians</td>
<td>111810101.3.20</td>
<td>IT-13.1</td>
<td>111810101.3.21</td>
</tr>
<tr>
<td></td>
<td>111810101.3.21</td>
<td>IT-13.2</td>
<td>111810101.3.22</td>
</tr>
<tr>
<td><strong>Related Category 3</strong></td>
<td><strong>Outcome Measure(s):</strong></td>
<td><strong>Pain assessment (NQF-1637) (Non-standalone measure)</strong></td>
<td><strong>Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone measure)</strong></td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
</tr>
<tr>
<td>Milestone 2 Estimated incentive payment: $ 742,330</td>
<td>semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>accomplished Baseline: 2012 transition rate for patients receiving a palliative care consultation was 58% (679) transitions. Goal: Increase transitions accomplished by 937 over baseline Data Source: EHR, data warehouse, palliative care database</td>
<td>hospitalized terminally-ill patients who receive a palliative care consult to 70%. Data Source: EHR, data warehouse, palliative care database</td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $1,484,661</td>
<td>Year 3 Estimated Milestone Bundle Amount: $1,674,429</td>
<td>Year 4 Estimated Milestone Bundle Amount: $1,741,406</td>
<td>Year 5 Estimated Milestone Bundle Amount: $1,666,987</td>
</tr>
<tr>
<td>Total Estimated Incentive Payments for 4-Year Period: $6,567,483</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Project Option 2.11.1- 2.11 Conduct Medication Management: Patient-Centered Medication Therapy Management Program

**Unique RHP Project ID:** 111810101.2.5  
**Performing Provider Name/TPI:** UTHealth, UTPhysicians / 111810101

**Project Summary:**

Provider: UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

**Intervention(s):** This project will implement a technologically driven patient-centered medication therapy management program. Allscripts analytics tool will enable staff to identify patients at high risk for developing complications and co-morbidities, and patients that have not refilled their medications. Patients will also have access to the patient portal, which will have detailed information on all their medications. Root cause analysis will be used to identify potential medication errors and quality improvement processes will be used to address the causes.

**Need for the project:** Drug-related morbidity and mortality costs exceed $200 billion annually in the U.S. Patients with multiple chronic conditions are likely to be on multiple medications for long periods of time thereby increasing the risk of medication errors. Considering the high rates of chronic diseases in our region, this project will lead to improved outcomes and cost savings for the health system.

**Target Population:** This project primarily targets patients in our service areas with diabetes, hypertension, asthma, COPD, or CHF. Patients of lower socioeconomic status are known to have worse disease control due to inability to maintain compliance in the long run, hence this project will be beneficial to the Medicaid population. UTP provided 321,716 patient visits in 2012 (20% were Medicaid clients) and expects to add another 80,000 patient visits (most are expected to be Medicaid clients) by the end of FY5, due to the UTP expansion of primary and specialty care services.

**Category 1 or 2 expected patient benefits:**

By implementing this patient medication therapy management program, we expect to provide medication management for at least **9,000** unique patients with Asthma, CHF, COPD, Diabetes, or Hypertension and medication reconciliation for an estimated **150,000** patient visits.

**Category 3 outcomes:**

The percentage of members 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test (IT-1.2); the percentage who received at least 180 treatment days of digoxin and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test (IT-1.3), and the percentage who received at
least 180 treatment days of a diuretic and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year (IT-1.4).
Project Option 2.11.1 – Conduct Medication Management: Patient-Centered Medication Therapy Management Program

**Unique RHP Project Identification Number:** 111810101.2.5  
**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Project Description:** 2.11 Conduct Medication Management (Option 2.11.1)

UT Physicians will implement a patient-centered medication therapy management program. Using the Allscripts analytics tool, staff will identify patients at high risk for developing complications and adverse effects from possible interactions, or non-compliance. Related patient information in the EMR will be used to review the complete medication regimen and history to assess compliance. Where there is an indication that a patient might not be compliant (Rx wasn’t filled, etc.), or there are other reasons for concern, the appropriate member of the patient’s healthcare team will follow up with the patient. Patients of UTP will receive counseling and education about the medications they are prescribed and an action plan will be developed that includes any further patient education needed, goal setting, and follow up appointments for potential adjustments in the medication regimen. Patient response will then be monitored and adjustments made accordingly. Patients will also have access 24/7 to the Jardogs patient portal, which will have a complete list of all current medications, including dosage information, information on how and why it is being used, and the prescribing physician. Patients will be educated on accessing the patient portal. The patient’s healthcare team continue to work with the patient in resolving any barriers to compliance that could include any number of things. Root cause analysis will be done to identify reoccurring barriers to compliance and potential medication errors, and quality improvement processes will be used to address the causes.

Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.

**Goal and Relationship to Regional Goals:**

**Project Goal:**
To provide information to physicians, care teams, and patients that facilitates the appropriate use of medications in order to control illness and promote health.

This project addresses the following regional goal:
Part of the goals of the region is to develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices; the medication management project ties closely with this aspiration by using technological support to reduce medication errors and improve drug compliance.

**Challenges:**
Need: 1) High rates of chronic disease. 2) High risk of medication errors with polypharmacy.
Implementation: 1) Choosing the parameters that will be used to initiate action. 2) Implementing clinical processes to support proactive care. 3) Patient compliance with medication management efforts.

The medication management project will reduce the risk of medication errors in patients with multiple chronic conditions.

5-Year Expected Outcome for Provider and Patients:
Achievement of reduction in medication errors and drug interactions, resulting in improved adherence to chronic care medication therapy. By adopting a proactive medication therapy management program, potential dangerous interactions and ineffective treatment regimens can be avoided. Patients of UT Physicians, including the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base, will be safer and experience better health outcomes. In FY 2012, UTP provided 321,716 patient visits and expects to add another 80,000 (most of which are expected to be Medicaid clients) by DY5 for over 400,000 patient visits. Using the Harris County rate (14.5%) of Medicaid clients, there are an estimated 1,423,176 Medicaid clients living within our service areas. We expect this program will help ensure these clients will also get the best health outcomes possible from their medication therapies.

By implementing this patient medication therapy management program, we expect to provide medication management for at least 9,000 unique patients with Asthma, CHF, COPD, Diabetes, or Hypertension and medication reconciliation for an estimated 150,000 patient visits.

Starting Point/Baseline:
UT Physicians currently utilizes an electronic health record system called Allscripts. At this time, the only functionality the system has to perform medication therapy management is immediate medication reconciliation. Currently this is not a mandatory step in the staff’s process nor have reports been built to track this process. Allscripts has the ability to perform other functions of medication therapy management but they are not authorized for use at this time. A DY2 report showed that 12,879 unique patients were diagnosed with one of the chronic conditions of Asthma, CHF, COPD, Diabetes and Hypertension.

Rationale:
Patients with chronic diseases and multiple chronic conditions are likely to be on multiple medications for long periods of time thereby increasing the risk of medication errors. Considering the high rates of chronic diseases in our region, this project would potentially lead to improved outcomes and cost savings for the health system.

**Project Components:**

Through the Patient-Centered Medication Therapy Management Program, we propose to meet all the required project components listed below.

a) UTP will develop criteria and identify targeted patient populations (e.g. chronic disease patient populations that are at high risk for developing complications, co-morbidities, and/or utilizing acute and emergency care services) using evidence-based criteria for medication management planning.

b) UTP will develop written medication management plans and tools to provide education and support to those patients at highest risk of non-compliance, an adverse drug event, or medication error.

c) UTP will implement an electronic tracking and alert system using Allscripts. UTP will recruit additional staff where necessary to conduct periodic medication reviews.

d) UTP will conduct root cause analysis of non-compliance, potential medication errors, or adverse drug events and develop/implement processes to address those causes.

e) UTP’s quality improvement office will conduct QI for each of the clinics providing specialty care using methods such as rapid cycle improvement.

**Milestones and Metrics:**

For the Patient-Centered Medication Therapy Management Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

**Process Milestones and Metrics:**

Milestone 1 [P-X1.]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign

Metric 1 [P-X1.1.]: Implementation plan (eligibility criteria, implementation components, responsibilities, and timeline).

Milestone 2 [P-X2.]: Designate/hire personnel or teams to support and/or manage the project/intervention

Metric 1 [P-X2.1.]: Project managers, personnel assigned to teams, and team responsibilities

Milestone 3 [P-2.]: Develop criteria and identify targeted patient populations

Metric 1 [P-2.1.]: Establish evidence based criteria for medication management planning in target population based on assessment of population needs

Milestone 4 [P-2.]: Develop criteria and identify targeted patient populations

Metric 1 [P-2.2.]: Written medication management plan(s)

Milestone 5 [P-X.]: Establish a baseline, in order to measure improvement over self

Metric 1 [P-X.3.]: Based on established criteria, assess and document estimated number of patients in need of medication management

Milestone 6 [P-1.]: Implement a medication management program
Metric 1 [P-1.1.]: Program elements

Improvement Milestones and Metrics:

Milestone 7 [I-8.]: Identify patients with chronic disease who receive medication management in their discharge instructions appropriate for their chronic disease.

Metric 1 [I-8.1.]: X percent increase of patients with chronic disease who receive appropriate disease specific medication management

Milestone 8 [I-9.]: Manage medications for targeted patients

Metric 1 [I-9.1.]: Increase the number of patients (meeting criteria for chronic condition) contacted or receiving medication management

Milestone 9 [I-13.]: Implement electronic medication reconciliation at the point of care

Metric 1 [I-13.1.]: Increase the number of patients that receive electronic medication reconciliation at the point of care

Unique community need identification numbers the project addresses:

This project addresses community needs CN.11 (High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease).

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

This project represents a new initiative. UT Physicians have not previously had access to these types of tools and processes for ensuring the safety of their patients receiving medication therapy and for achieving patients goals.

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management

• IT-1.2 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)219– angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non-standalone measure)

Percentage of members 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

OD-1 Primary Care and Chronic Disease Management

• IT-1.3 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)– digoxin (Non- standalone)

Percentage of members 18 years of age and older who received at least 180 treatment days of digoxin during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

OD-1 Primary Care and Chronic Disease Management

• IT-1.4 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)– diuretic (Non- standalone measure)

Percentage of members 18 years of age and older who received at least 180 treatment days of a diuretic during the measurement year and had at least one serum potassium and
either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

**Relationship to other Projects:**
1.1 (C3) - The medication management program will be an integral part of the coordinated care provided by the primary care physicians.
1.2 (A2, SPH1) - Structured educational training for health care providers on quality and cost control will entail instruction in medication therapy management for minimizing medication errors.
1.3 (C12) - The disease management registries and the medication management project will complement each other to ensure patients with chronic diseases, especially those with multiple chronic conditions, get optimal care with minimal errors and sustained active follow up.
1.6 (C11) - The medication management program with its technological support will provide the nurses with useful information on patients to inform more efficient triaging.
1.7 (A1) - The medication management project will ensure that patient medications are managed in a coordinated manner even with inputs and prescriptions from specialists at different sites.
1.9 (C4) - The medication management project will serve as a useful resource to every provider involved in managing the enrolled patients, to ensure optimum outcomes.
2.1 (C1-2) - The medication management program will be an integral component of the provision of care within the medical home model.
2.2 (C5-9,CL3) - The medication management program will be an important resource for the provision of chronic disease care using Wagner's model as proposed in these projects.
2.10 (MS3) - The medication management program will be a useful resource for those providing palliative care to reduce the risk of medication errors and in achieving patient goals for care.
2.15 (C13) - The medication management program will be a useful resource for the primary care physicians and the behavioral health physicians providing integrated care.

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

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

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. **Transformational Impact** (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. **Population Served/Project Size** (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.

3. **Aligned with Community Needs** (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. **Cost Avoidance** (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects.

5. **Partnership/Collaboration** (Weight = 10%): *This was not rated*, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. **Sustainability** (Weight = 15%): *This was also not rated*, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
### Patient-Centered Medication Therapy Management Program

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-X1.]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign</td>
<td><strong>Milestone 3</strong> [P-2.]: Develop criteria and identify targeted patient populations</td>
<td><strong>Milestone 6</strong> [P-1.]: Implement a medication management program</td>
<td><strong>Milestone 8</strong> [I-9.]: Manage medications for targeted patients</td>
</tr>
<tr>
<td>Metric 1 [P-X1.1.]: Implementation plan (eligibility criteria, implementation components, responsibilities, and timeline). Goal: Complete and document program plans including goals, objectives and action plans Data Source: program materials</td>
<td>Metric 1 [P-2.1.]: Establish evidence based criteria for medication management planning in target population based on assessment of population needs Goal: The project team will identify the target populations and needs for medication management. They will also establish evidence-based criteria to be used for the program. Data Source: Written criterion for target population and program participation</td>
<td>Metric 1 [P-1.1.]: Program elements Goal: Documentation of all program elements Data Source: Written medication management plan including workflow for providers.</td>
<td>Metric 1 [I-9.1.]: Increase the number of patients (meeting criteria for chronic condition) contacted or receiving medication management Goal: 4,500 Data Source: Paper or electronic medical record</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-X2.]: Designate/hire personnel or teams to support and/or manage the project/intervention</td>
<td><strong>Milestone 4</strong> [P-2.]: Develop criteria and identify targeted patient populations</td>
<td><strong>Milestone 7</strong> [I-8.]: Identify patients with chronic disease who receive medication management in their discharge instructions appropriate for their chronic disease.</td>
<td><strong>Milestone 9</strong> [I-13.]: Implement electronic medication reconciliation at the point of care</td>
</tr>
<tr>
<td>Metric 1 [P-X2.1.]: Project managers, personnel assigned to teams, and team responsibilities Baseline/Goal: Designate team</td>
<td>Metric 1 [P-2.2.]: Written medication management plan(s)</td>
<td>Metric 1 [I-8.1.]: X percent increase of patients with chronic disease who receive appropriate disease specific medication management Baseline: The number of unique patients with chronic condition of Asthma, CHF, COPD, Diabetes and Hypertension is 12,879, but we do</td>
<td>Metric 1 [I-13.1.]: Increase the number of patients that receive electronic medication reconciliation at the point of care Baseline: Baseline established in DY3 Goal: 80% of all patients taking 4, or more medications, will have electronic medication reconciliation performed at the point of care.</td>
</tr>
</tbody>
</table>

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

- 111810101.3.23 IT-1.2
- 111810101.3.24 IT-1.3
- 111810101.3.25 IT-1.4

For the full list of outcome measures and goals, please refer to the original document.
### Related Category 3
**Outcome Measure(s):**

<table>
<thead>
<tr>
<th>IT-1.2</th>
<th>IT-1.3</th>
<th>IT-1.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) 219– angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non-standalone measure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – digoxin (Non-standalone)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – diuretic (Non-standalone measure)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Members, Roles, and Responsibilities**
Data Source: UT Physicians’ report, policy, contract or other documentation

**Milestone 2 Estimated Incentive Payment:** $814,168

Goal: Develop written medication plans for the conditions, criteria, and protocols identified by the project implementation team.
Data Source: Paper or electronic medical record citing medication management counseling provided; medication reconciliation documented in paper or electronic medical record

**Milestone 4 Estimated Incentive Payment:** $612,157

**Milestone 5 [P-X.]: Establish a baseline, in order to measure improvement over self**

**Metric 1 [P-X.3.]:** Based on established criteria, assess and document estimated number of patients in need of medication management
Baseline/Goal: Based on the identified populations for the intervention and the criteria for inclusion, a baseline will be established for use in measuring improvement over self for 1) number not have a medication management program.
Goal: Increase by 35% over baseline the number of patients with chronic disease who are receiving disease specific medication management.
Data Source: Chronic disease registry and hospital EHR

**Milestone 6 Estimated Incentive Payment:** $954,965

**Milestone 9 Estimated Incentive Payment:** $914,154

Data Source: Paper or electronic health record

Data Source: Paper or electronic health record

Milestone 9 Estimated Incentive payment: $914,154
<table>
<thead>
<tr>
<th>111810101.2.5</th>
<th>2.11.1</th>
<th>A-D</th>
<th>PATIENT-CENTERED MEDICATION THERAPY MANAGEMENT PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>UTHealth, UTPhysicians</td>
</tr>
<tr>
<td>Related Category 3</td>
<td>111810101.2.23</td>
<td>IT-1.2</td>
<td>Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)219– angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non-standalone measure)</td>
</tr>
<tr>
<td>Outcome Measure(s):</td>
<td>111810101.2.24</td>
<td>IT-1.3</td>
<td>Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)– digoxin (Non-standalone)</td>
</tr>
<tr>
<td></td>
<td>111810101.2.25</td>
<td>IT-1.4</td>
<td>Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)– diuretic (Non-standalone measure)</td>
</tr>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
<td></td>
<td><strong>Year 2 Estimated Milestone Bundle Amount: $1,628,337</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Year 3 Estimated Milestone Bundle Amount: $1,836,471</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Year 4 Estimated Milestone Bundle Amount: $1,909,930</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Year 5 Estimated Milestone Bundle Amount: $1,828,309</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $7,203,047</strong></td>
</tr>
</tbody>
</table>

of patients with Asthma, CHF, COPD, Diabetes, or Hypertension that are receiving medication management and 2) the number of all patients receiving electronic medication reconciliation.

Data Source: Assessment report

Milestone 5 Estimated incentive payment: $612,157
Project Option 2.12.2- 2.12 Implement/Expand Care Transitions Programs: UT Physicians
Transitions of Care

**Unique RHP Project ID:** 111810101.2.6  
**Performing Provider Name/TPI:** UTHealth, UTPhysicians / 111810101

**Project Summary:**

Provider: UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

**Intervention(s):** This project will implement a comprehensive transitions of care program which will ensure that patients have an appointment for follow-up with an appropriate physician(s) prior to leaving the hospital, understand their discharge medications and other instructions, and are followed up post discharge, particularly those at risk of needing acute care services within 30-60 days. This will be implemented with UT Physicians' network of hospitalists with 24/7 management of inpatients with specific medical and surgical conditions.

**Need for the project:** This project addresses several community needs including insufficient access to care coordination practice management and high rates of preventable hospital readmissions. When a patient is discharged without optimal follow-up, it could lead to hospital readmission and possibly death. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays.

**Target Population:** The care transitions project will be for special populations, namely: cancer surgery patients, patients admitted for DKA, and children/adolescents with type 1 diabetes who are graduating to adult diabetes management.

**Category 1 or 2 expected patient benefits:**
Through this transitions of care project that targets 3 specific groups at high risk for in-patient hospitalization, we expect to have completed evidence-based care transitions processes for approximately 2,000 unique patients, which will help to ensure continuity of care, better health outcomes, and fewer hospitalizations.

**Category 3 outcomes:**
Our goal is to reduce potentially preventable re-admissions (PPRs) for any cause for patients with diabetes (IT-3.3).
Project Option 2.12.2 – Implement/Expand Care Transitions Programs: UT Physicians

Transitions of Care

Unique RHP Project Identification Number: 111810101.2.6
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 2.12 Implement/Expand Care Transitions Programs (Option 2.12.2)

There is evidence that care coordination and transitional care can reduce unplanned hospital readmissions, which are an indicator of quality of care and a source of significant wasted hospital resources and expenditures. Care coordination is defined by the Agency for Healthcare Research and Quality (AHRQ) as the "deliberate organization of patient care activities between two or more participants (including the patients) involved in a patient's care to facilitate the appropriate delivery of health care services."( McDonald KM, Sundaram V, Bravata DM, et al. Care Coordination. Vol 7 of: Shojania KG, McDonald KM, Wachter RM, Owens DK, editors. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9 (Prepared by the Stanford University-UCSF Evidence-based Practice Center under contract 290-02-0017). AHRQ Publication No. 04-(07)-0051-7. In. Rockville, MD: Agency for Healthcare Research and Quality; June 2007.) Transitional care, which is complementary to care coordination, is "a broad range of time-limited services designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another."

(Naylor MD, Aiken LH, Kurtzman ET, Olds DM, Hirschman KB. The care span: The importance of transitional care in achieving health reform. Health Aff (Millwood) 2011;30:746-54.)

UT Health proposes to implement a comprehensive transitions of care program. UT Physicians will implement a discharge planning program and post discharge support program that ensures that patients have an appointment for follow-up with an appropriate physician(s) prior to leaving the hospital, understand their discharge medications and other instructions, and are followed up post discharge, particularly those at risk of needing acute care services within 30-60 days. This will be implemented with UT Physicians' network of hospitalists with 24/7 management of inpatients with medical and surgical conditions. Additionally, we have planned specific transitions of care interventions for certain special populations.

Successful care coordination and transitional care programs have traditionally been implemented for medical rather than surgical patients and in settings where patients have ready access to primary care providers. Cancer care and outcomes are worst among racial/ethnic minorities and uninsured patients and at safety-net hospitals serving a disproportionate percentage of these patients. Cancer surgery at safety-net hospitals has been associated with delays, or failures, in receiving treatment (both surgical and adjuvant) and an increased risk of death. In addition, major postoperative complications and readmissions occur commonly among cancer surgery patients, both of which are associated with increased risk of death; readmission rates after complex surgery have been reported to be as high as 59% in one year. Transitions to home after cancer surgery can be difficult because of pain, decreased function and mobility, and surgery-related symptoms or complications. These transitions may be even more difficult among patients with limited social support, reduced health literacy, and unclear expectations regarding post-operative recovery. Comprehensive care programs for high-risk neonates and chronically ill
children have been successfully implemented in resource-poor, inner-city settings (Dallas and Houston, Texas) by Dr. Jon Tyson (UT Health). Both of these programs resulted in significantly reduced healthcare utilization (intensive care unit admissions, hospitalizations, emergency room visits) and costs. The comprehensive care program for chronically ill children in Houston was associated with a difference in combined inpatient and outpatient costs per year of almost $20K (preliminary analyses). (Broyles RS, Tyson JE, Heyne ET, et al. Comprehensive follow-up care and life-threatening illnesses among high-risk infants: A randomized controlled trial. Jama 2000;284:2070-6.) Thus, there is good rationale and evidence to suggest that a comprehensive transitional care program would reduce readmissions and emergency room visits without increasing costs in high-risk surgical patients. The program could have other potential benefits such as: decreased patient anxiety and increased patient satisfaction; improved quality of care (and care coordination); improved access to specialty care; and reduced disparities in surgical and cancer-specific outcomes. A comprehensive care coordination and transitions program will be developed and implemented for cancer surgery patients, which will provide deliberate organization of patient care activities between all care givers and participants (including the patients) involved in a patient's care that facilitates the right care at the right time and ensures continuity of care, avoids preventable poor outcomes, and promotes the safe and timely transfer of patients from one level of care to another, or from one type of setting to another.

In addition to targeting cancer surgery patients, we will also provide transitions of care targeting patients admitted with DKA. Often the indigent patients keep cycling back and forth in the hospital with multiple DKA admissions. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays. Hence, intensive monitoring as part of this project is needed to improve treatment compliance and reduce readmission rates in these patients. This enhanced transitions of care project could improve diabetes-related health outcomes in indigent patients with diabetes, who are prone to occurrence of diabetic ketoacidosis (DKA). With the addition of critical personnel to Endocrine Services, practice providers will: 1. Survey daily hospital admissions for diagnosis of DKA, 2. Visit patients, explain the program, and schedule patients for outpatient follow-up in the DKA clinic within 2 weeks of discharge, 3. Maintain contact with the patient at home to facilitate home insulin treatment and ensure outpatient clinic visit on appointed day, 4. Work with Dr. Orlander (UT) to ensure appropriate outpatient testing and care for the patient, and 5. Maintain a DKA database to monitor cost-effectiveness and clinical outcomes over time.

Also, children and adolescents with type 1 diabetes or other forms of early onset diabetes need a well-structured transitional care program to move from (usually highly organized) pediatric diabetes management to (usually less structured, more self-managed) adult diabetes management at the age of 18 years. The first encounter of “graduating” pediatric diabetic patients with the adult health care system is often in the hospital ED in diabetic ketoacidosis due to a lack of insulin or an untreated acute illness. DKA is a highly preventable cause of medical admission and could result in death. Children with type 1 diabetes constitute a special needs population as there is currently no program that pays special attention to their peculiar needs when "graduating" to adult care. Advanced practice providers will identify all adolescent diabetic patients who will “graduate” from pediatric to adult diabetes specialist care in the following 6 months, work with the patients and their parents to arrange the first adult diabetes clinic visit, ensure continuing supply of insulin and other necessary medications during the transition, and
arrange for diabetes education in self-management as an adult diabetic patient, and maintain a database for outcomes of this project.

**Goal and Relationship to Regional Goals:**

*Project Goal:*

To implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions.

*This project addresses the following regional goal:*

Care transitions project will make it easier for patients to access care in a coordinated manner, thereby attaining the regional goal to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services..."

**Challenges:**

Need: 1) High rates of preventable hospital readmissions. 2) Insufficient access to care coordination practice management and integrated care treatment programs.

Implementation: 1) Ability to provide culturally appropriate discharge support. 2) Tackling barriers to compliance such as inability to afford care, transportation, and low literacy levels. 3) Identifying the main barriers and facilitators of implementing a comprehensive care program. 4) Designing a feasible, effective, and self-sustainable program to address the problem of Unplanned readmissions. 5) Coordinating care across multiple services. 6) Determining which components of the multi-level program are most effective and efficient for which patients.

Dr. Jon Tyson's expertise in designing and implementing comprehensive care programs will assist us in addressing the implementation challenges.

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

This transitional care project will provide "a broad range of time-limited services designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another." The at-risk populations will include the Medicaid and Medicaid-eligible patients of Memorial Hermann Hospital and UT Physicians. Patients receiving timely care, appointments and information, will have better outcomes and improved patient satisfaction.

Through this transitions of care project that targets 3 specific groups at high risk for inpatient hospitalization, we expect to have completed evidence-based care transitions processes for approximately **2,000 unique patients**. Through these transitions of care processes, if only 1 in-patient admission (estimated cost of about $25,000 each) is prevented for 20% of these unique patients, the project would have already paid for itself by the end of DY5. A very conservative estimate of the proportion of these that would be Medicaid, or Medicaid-eligible, is approximately 460. The proportion of DKA admissions that are for Medicaid, or Medicaid-eligible, patients in particular is expected to run at a much higher rate.

**Starting Point/Baseline:**

This is a new project, so baseline is set at zero. Targets are based upon current number of patients in target groups and project capacity. In 2012, UT Physicians conducted 2,324 cancer surgeries at MHH-TMC for 752 unique patients, for an average of just over 3 surgeries per
patient. In the same year, UT Physicians at MHH-TMC attended 474 DKA admissions for 144 unique patients. Over 42% of patients admitted for DKA had 4, or more, DKA admission that same year. UT Physicians currently has 178 adolescent patients with Type 1 diabetes that will be transitioning to adult care by the end of DY5.

**Rationale:**

When a patient is discharged without optimal follow-up, it could have terrible consequences such as hospital readmission and possibly death. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with proactive post-discharge support, can reduce readmission rates and improve health outcomes.

**Project Components:**

Through the UT Physicians Transitions of Care Program, we propose to meet all required project components listed below.

1) UTP will recruit additional staff to manage the transitions of care program.
2) UTP will work with MHH to develop processes using best practices and evidence-based protocols for effectively communicating with patients and families during discharge to improve adherence to discharge and follow-up care instructions. These processes will include:
   a. Use of discharge checklists,
   b. Development of post-discharge medication planning,
   c. Arranging post-op clinic visit before discharge,
   d. Development of “Hand off” communication plans between providers, and
   e. Provision of patient and family post-operative recovery education and wellness education.
3) UTP will conduct follow-up contacts with discharged patients using automated flags and reminders.

**Milestones and Metrics:**

For the UT Physicians Transitions of Care Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

**Process Milestones and Metrics:**

**Milestone 1 [P-X.]:** Complete a planning process/submit a plan for the implementation of a major program/process redesign
Metric 1 [P-X.1.]: Implementation plan (eligibility criteria, implementation components, responsibilities, and timeline).

**Milestone 2 [P-X.]:** Designate/hire personnel or teams to support and/or manage the project/intervention
Metric 1 [P-X.2.]: Project managers, personnel assigned to teams, and team responsibilities

**Milestone 4 [P-1.]:** Develop best practices or evidence-based protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions.
Metric 1 [P-1.1.]: Care transitions protocols

**Milestone 5** [P-1.]: Develop best practices or evidence-based protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions.

Metric 1 [P-1.1.]: Care transitions protocols

**Milestone 6** [P-1.]: Develop best practices or evidence-based protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions.

Metric 1 [P-1.1.]: Care transitions protocols

**Milestone 7** [P-7.]: Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program

Metric 1 [P-7.1.]: Documentation of the staffing plan.

**Milestone 8** [P-2.]: Implement standardized care transition processes

Metric 1 [P-2.1.]: Care transitions policies and procedures

**Milestone 9** [P-2.]: Implement standardized care transition processes

Metric 1 [P-2.1.]: Care transitions policies and procedures

**Milestone 10** [P-2.]: Implement standardized care transition processes

Metric 1 [P-2.1.]: Care transitions policies and procedures

**Milestone 11** [P-12.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

Metric 1 [P-12.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Milestone 12** [P-12.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

Metric 1 [P-12.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Improvement Milestones and Metrics:**

**Milestone 3** [I-10.]: Identify the top chronic conditions (e.g., heart attack, heart failure and pneumonia) and other patient characteristics (e.g., medical home assignment and demographics such as age) or socioeconomic factors (e.g., homelessness) that are common causes of avoidable readmissions

Metric 1 [I-10.1.]: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of re-admissions.

**Milestone 12** [I-14]: Implement standard care transition processes in specified patient populations.

Metric 1 [I-14.1]: Measure adherence to processes.

**Milestone 13** [I-14]: Implement standard care transition processes in specified patient populations.

Metric 1 [I-14.1]: Measure adherence to processes.

**Milestone 15** [I-14]: Implement standard care transition processes in specified patient populations.

Metric 1 [I-14.1]: Measure adherence to processes.

**Milestone 16** [I-14]: Implement standard care transition processes in specified patient populations.
Metric 1 [I-14.1]: Measure adherence to processes.

**Milestone 17** [I-14]: Implement standard care transition processes in specified patient populations.

Metric 1 [I-14.1]: Measure adherence to processes.

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

This project addresses community needs CN.6 (Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly), CN.7 (Insufficient access to care coordination practice management and integrated care treatment programs), CN.9 (High rates of preventable hospital readmissions), and CN.10 (High rates of preventable hospital admissions).

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

The project represents a new initiative. UT Physicians does not currently have any of the transitions of care initiatives described in this project.

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

OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs )

- IT-3.3 Diabetes 30 day readmission rate (Standalone measure)

Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.

**Relationship to other Projects:**

1.1 (C3) - The expanded capacity to deliver primary care will ensure that patients are able to be assigned to a care team in the UT medical homes.

1.2 (A2, SPH1) - The innovative residency program and the training of community health workers will ensure availability of human resources to facilitate the transition of patients between care givers in a medical home.

1.3 (C12) - The disease management registry will be a useful resource for the care team in ensuring that continuity of care is maintained.

1.7 (A1) - Telemedicine capabilities within the UT Medical Homes will provide increased capacity to deliver both primary and specialty care services to patients when and where needed.

1.9 (C4) - The expansion of specialty care in the primary care setting will provide a greater availability of needed services for cancer patients with complex needs.

2.1 (C1-2) - The UT Health Multispecialty Physician Group will provide an extensive network of specialty support centers for primary care providers in advanced medical homes, better equipped to care for patients transitioning from acute care who have complex needs.

2.2 (C5-9,CL3) - The chronic care management models being implemented within the UT Medical Homes will provide improved care for cancer patients who must also manage a chronic disease.
**Relationship to Other Performing Providers’ Projects in the RHP:**

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

**Plan for Learning Collaborative:**

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

**Project Valuation:**

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. **Transformational Impact** (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. **Population Served/Project Size** (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.

3. **Aligned with Community Needs** (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. **Cost Avoidance** (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects.

5. **Partnership/Collaboration** (Weight = 10%): **This was not rated**, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.
6. **Sustainability** (Weight = 15%): *This was also not rated*, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong> [P-X.]: Complete a planning process/submit a plan for the implementation of a major program/process redesign</td>
<td><strong>Milestone 4</strong> [P-1.]: Develop best practices or evidence-based protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions.</td>
<td><strong>Milestone 8</strong> [P-2.]: Implement standardized care transition processes</td>
<td><strong>Milestone 14</strong> [P-12.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.</td>
</tr>
<tr>
<td><strong>Metric 1</strong> [P-X.1.]: Implementation plan (eligibility criteria, implementation components, responsibilities, and timeline). Goal: Complete and document plans including goals, objectives and action plans</td>
<td><strong>Metric 1</strong> [P-1.1.]: Care transitions protocols Goal: Create and obtain final approval for the protocols and updated policies and procedures for <strong>DKA admissions</strong> Data Source: Submission of protocols, Care transitions program materials</td>
<td><strong>Metric 1</strong> [P-2.1.]: Care transitions policies and procedures Goal: Staff will be trained and transitions processes implemented for <strong>DKA admissions</strong> Data Source: Policies and procedures of care transitions program materials</td>
<td><strong>Metric 1</strong> [P-12.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: attend 2 meetings per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
</tr>
<tr>
<td>Data Source: Care transitions program materials</td>
<td><strong>Milestone 4 Estimated incentive payment:</strong> $ 756,194</td>
<td><strong>Milestone 8 Estimated incentive payment:</strong> $ 524,295</td>
<td><strong>Milestone 14 Estimated incentive payment:</strong> $ 752,833</td>
</tr>
<tr>
<td><strong>Milestone 2</strong> [P-X.]: Designate/hire personnel or teams to support and/or manage the project/intervention</td>
<td><strong>Milestone 5</strong> [P-1.]: Develop best practices or evidence-based protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions.</td>
<td><strong>Milestone 9</strong> [P-2.]: Implement standardized care transition processes</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Outcome Measure(s)</td>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>------</td>
<td>-------------------</td>
<td>--------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>111810101.3.26</td>
<td>Diabetes 30 day readmission rate (Standalone measure)</td>
<td>Milestone 2 Estimated incentive payment: $ 893,989</td>
<td>Milestone 3 Estimated incentive payment: $ 893,989</td>
</tr>
<tr>
<td>IT-3.3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 2** Estimated incentive payment: $ 893,989

**Milestone 3 [I-10.]** Identify the top chronic conditions (e.g., heart attack, heart failure and pneumonia) and other patient characteristics (e.g., medical home assignment and demographics such as age) or socioeconomic factors (e.g., homelessness) that are common causes of avoidable readmissions.

**Milestone 5 Estimated incentive payment: $ 893,989**

**Milestone 6 [P-1.]:** Develop best practices or evidence-based protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions.

**Metric 1 [P-1.1.]:** Care transitions protocols

Goal: Create and obtain final approval for the protocols and updated policies and procedures for diabetic (type 1) adolescents graduating from pediatric care to adult care

Data Source: Submission of protocols, Care transitions program materials

Milestone 6 Estimated incentive payment: $ 756,194

**Milestone 10 Estimated incentive payment: $ 524,294**

**Milestone 11 [P-12.]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

**Metric 1 [P-12.1.]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

Baseline/Goal: attend 2 meetings per year

Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

Milestone 11 Estimated incentive payment: $ 524,294

**Milestone 12 [I-14]:** Implement standard care transition processes in specified patient populations.

Metric 1 [I-14.1]: Measure adherence to processes.

Goal: 90% of diabetic (type 1) adolescents graduating from pediatric care to adult care are followed-up according to transitions of care protocols.

Data Source: Administrative data and EMR.

**Milestone 16 Estimated incentive payment: $ 752,833**

**Milestone 17 [I-14]:** Implement standard care transition processes in specified patient populations.

Metric 1 [I-14.1]: Measure adherence to processes.

Goal: 90% of diabetic (type 1) adolescents graduating from pediatric care to adult care are followed-up according to transitions of care protocols.

Data Source: Administrative data and EMR.
<table>
<thead>
<tr>
<th>111810101.2.6</th>
<th>2.12.2</th>
<th>A-F</th>
<th>UT Physicians Transitions of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTHealth, UTPhysicians</td>
<td>111810101</td>
<td>Diabetes 30 day readmission rate (Standalone measure)</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

and implementation plan to accomplish the goals/objectives of the care transitions program

**Metric 1 [P-7.1]:** Documentation of the staffing plan.
Goal: Develop and implement staffing plan for each of the 4 transitions processes
Data Source: Staffing and implementation plan.

Milestone 7 Estimated incentive payment: $ 756,193

standard care transition processes in specified patient populations .

**Metric 1 [I-14.1]:** Measure adherence to processes.
Goal: 80% of patients admitted to MHH-TMC for DKA are followed-up according to transitions of care protocols.
Data Source: Administrative data and EMR.

Milestone 12 Estimated incentive payment: $ 524,294

**Milestone 13 [I-14]:** Implement standard care transition processes in specified patient populations .

**Metric 1 [I-14.1]:** Measure adherence to processes.
Goal: 65% of cancer surgery patients at MHH-TMC are followed-up according to transitions of care protocols.
Data Source: Administrative data and EMR.

Milestone 13 Estimated incentive payment: $ 524,294

Milestone 17 Estimated incentive payment: $ 752,833

Year 2 Estimated Milestone Bundle Amount: $2,681,967
Year 3 Estimated Milestone Bundle Amount: $3,024,775
Year 4 Estimated Milestone Bundle Amount: $3,145,766
Year 5 Estimated Milestone Bundle Amount: $3,011,332
<table>
<thead>
<tr>
<th>Outcome Measure(s):</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT-3.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes 30 day readmission rate (Standalone measure)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $11,863,840
Project Option 2.15.1- 2.15 Integrate Primary and Behavioral Health Care Services: Integrated Primary and Behavioral Health Care Services

Unique RHP Project ID: 111810101.2.7
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider: UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s): UT Health will design, implement and evaluate a project that will integrate primary and behavioral healthcare services within UT Physicians’ clinics to achieve a close collaboration in a partly integrated system of care (Level IV). A behavioral health provider will be placed in the primary care setting to provide patients with behavioral health services at their usual source of health care. This will facilitate care coordination between primary and behavioral healthcare.

Need for the project: This project addresses several community needs including inadequate access to behavioral health care, and high rates of tobacco use and excessive alcohol use. The Health of Houston Survey, 2010, reported that 9% of residents did not see a behavioral health professional, even though they felt it was needed. Service integration will help to address the reasons care was not sought by the 31% that felt uncomfortable about it, the 22% that was concerned that someone would find out, the 17% that had trouble getting an appointment, and the 59% that had cost concerns.

Target Population: The service areas of our 4 outlying clinics include health professional shortage areas, and medically underserved areas and populations. Using the Harris County rate (14.5%) of Medicaid clients, there are an estimated 1,423,176 Medicaid clients living within our service areas. In FY 2012, UTP provided 321,716 patient visits and expects to add another 80,000 (most, of which are expected to be Medicaid clients) primary and specialty patient visits (not counting behavioral health) by DY5 for over 400,000 patient visits.

Category 1 or 2 expected patient benefits:
By DY5, we expect to have completed 24,074 behavioral health visits in an integrated program of primary care and behavioral health care. Of these, at least 5,537 are expected to be Medicaid visits.

Category 3 outcomes:
Our goals are to increase, the percentage of UT Physicians patients who receive screening for clinical depression using a standardized tool, and for whom a follow-up plan is documented (IT-1.8), and to increase the number of patients with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months (IT-1.9).
Project Option 2.15.1 – Integrate Primary and Behavioral Health Care Services: Integrated Adult Primary and Behavioral Health Care Services

Unique RHP Project Identification Number: 111810101.2.7
Performing Provider Name/TPI: UTHealth, UT Physicians/111810101

Project Description: 2.15 Integrate Primary and Behavioral Health Care Services (Option 2.15.1)

UT Health will design, implement and evaluate a project that will integrate primary and behavioral health care services within UT Physicians clinics to achieve a close collaboration in a partly integrated system of care (Level IV). The project will recruit and place behavioral health providers in UT Physicians’ primary care settings to provide patients with behavioral health services at their usual source of health care and will facilitate the coordination of care involving both primary and behavioral health. The project will focus on low behavioral health – low physical health complexity/risk (Quadrant I) and low behavioral health – high physical health complexity/risk (Quadrant III) of the Four Quadrant Model, which are most amendable to the primary care settings. This project will be structured to achieve level 4 (close collaboration in a partly integrated system, where providers share the same facility and share scheduling systems and medical records, and have regular face-to-face communication, functioning as a team), or preferably level 5, levels of interaction (close collaboration in a fully integrated system, where providers are part of the same team and system and the patient experiences mental health treatment as part of their regular primary care or vice versa). The need for any legal agreements that may be needed in a collaborative practice will be explored for this project, and in addition necessary arrangements will be made for facilities to achieve this service integration.

Along with the co-location of services, protocols, training, and team building will be implemented to improve communications and enhance coordination of care to deliver care that meets the needs of the whole person. Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.

Goal and Relationship to Regional Goals:
Project Goal:
Integrate primary care and behavioral health care services in order to improve care and access to needed services.
This project addresses the following regional goal:
Provision of both physical and behavioral health services in one location will make care more accessible to patients in a convenient location, and this relates to one of the goals of the region which is to "develop a regional approach to health care delivery that leverages and
improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction”.

Challenges:

Need: 1) Insufficient access to integrated care programs for behavioral health and physical health conditions. 2) Inadequate access to behavioral health care. 3) High rates of tobacco use and excessive alcohol use.

Implementation: 1) Motivation and ability of primary care and behavioral health teams to work together. 2) Patient awareness about service availability.

Despite high indicators of need, patients experience barriers in accessing behavioral health services, such as the stigma attached to mental health facilities and the inconvenience of adding another visit to their health care regimen. The integration of behavioral and primary care in this project enables patients to access coordinated efficient care in a convenient and less-stigmatized setting. Primary care providers will be trained to consult with and direct patients that may need behavioral health care services to the behavioral health provider. The behavioral health provider will have access to the patient’s records and be trained to consult with and direct patients to the primary care provider that may warrant further primary care services, or screenings. Patients will be able to address both behavioral health needs and primary care needs in a single visit.

5-Year Expected Outcome for Provider and Patients:

Attainment of a level 4 or 5 integration level in primary care and behavioral health will help to achieve optimal patient outcomes. This will lead to increased screening and better management of depression in the population served by UT Physicians and better health overall. In addition to benefiting the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base of UTP clinics, the program will be available to an additional 1,423,176 Medicaid and Medicaid-eligible residents living within the service areas of the UT Physician Clinics. In FY 2012, UTP provided 321,716 patient visits and expects to add another 80,000 (most, of which are expected to be Medicaid clients) primary and specialty patient visits (not counting behavioral health) by DY5 for over 400,000 patient visits.

With this project, we expect to deliver approximately 5,760 counseling sessions and 3,600 psychiatry session per year, for a total of 9,360 behavioral health visits per year, once fully ramped up. By DY5, we expect to have completed 24,074 behavioral health visits in an integrated program of primary care and behavioral health care. Of these, at least 5,537 are expected to be Medicaid visits. This is a very conservative estimate, because the growth in these clinics is expected to occur at a much higher payer mix for Medicaid than the current 23%.

Starting Point/Baseline:

There is currently no program in place for behavioral health services in any of our primary care clinics. Baseline metrics and measures will be all-inclusive from the outset of the program as defined in the milestones table and the Category 3 outcomes table. Currently, the 4 UTP community primary care clinics see 57,000 patient visits. Our expansion of primary care project for these clinics is expected to generate an additional 36,458 patient visits by the end of DY5, with at least 8,385 of them being Medicaid visits. In these clinics, there are currently already 1,097 adult patients with a mental health diagnosis that could benefit from this program. Furthermore, there is no current regular mental health screening that takes place in these clinics.

Regional Healthcare Partnership Plan  Region 3  1586
Rationale:

Patients will be able to receive care that is more convenient (located within their community and in a clinic offering extended hours), coordinated (ability to address both conditions in a single visit), and in a setting that reduces the stigma of receiving behavioral health services, since it is located within the primary care setting. The Health of Houston Survey, 2010, reported that 9% of residents did not see a behavioral health professional, even though they felt it was needed. The integration of behavioral health into the primary care setting will help to address the reasons care was not sought by the 31% that felt uncomfortable about it, the 22% that was concerned that someone would find out, the 17% that had trouble getting an appointment, and the 59% that were concerned about the cost. The primary care setting can provide increased continuity of care for behavioral health care problems, often occurring over extended periods of time, with symptoms that range from well-controlled to severe.

Project Components:

Through the Integrated Primary and Behavioral Health Care Services Program, we propose to meet all required project components listed below.

1. UTP will identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community.
2. UTP will develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated. UTP will also develop any necessary legal agreements that may be needed in a collaborative practice.
3. Also, protocols and processes for communication, data sharing, and referral between behavioral and physical health providers will be established that will include:
   a. Regular consultative meetings between physical health and behavioral health practitioners,
   b. Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners, and/or
   c. Shared treatment plans co-developed by both physical health and behavioral health practitioners.
4. UTP will recruit specialty providers (mental health and substance abuse) and support staff to provide mental health services in the primary care clinics.
5. UTP will train physical and behavioral health providers in protocols, effective communication and team approach.
6. UTP will acquire the necessary data reporting, communication and collection tools (equipment) to be used in the integrated setting.
7. UTP will develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.
8. UTP’s quality improvement office will conduct QI for each of the clinics providing specialty care using methods such as rapid cycle improvement.

Milestones and Metrics:

For the Integrated Primary and Behavioral Health Care Services Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.
**Process Milestones and Metrics:**

**Milestone 1** [P-1.]: Conduct needs assessment to determine areas of the state where the colocation of services has the potential to benefit a significant number of people who have physical/behavioral health needs  
Metric 1 [P-1.1.]: Numbers of patients in various areas who might benefit from integrated services: demographics, location, & diagnoses  

**Milestone 2** [P-2.]: Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new settings or for physicians to share their office space with behavioral health practitioners.  
Metric 1 [P-2.1.]: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations.  

**Milestone 3** [P-5.]: Develop integrated sites reflected in the number of locations and providers participating in the integration project.  
Metric 1 [P-5.1.]: Number of agreements signed for the provision of integrated services  
**Milestone 4** [P-5.]: Develop integrated sites reflected in the number of locations and providers participating in the integration project.  
Metric 3 [P-5.3.]: Number of behavioral health providers newly located in primary care clinics.  

**Milestone 5** [P-3.]: Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa.  
Metric [P-3.1.]: Number and types of referrals that are made between providers at the location  

**Milestone 6** [P-6.]: Develop integrated behavioral health and primary care services within colocated sites.  
Metric 1 [P-6.1.]: Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system).  

**Milestone 7** [P-10.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.  
Metric 1 [P-10.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.  

**Milestone 10** [P-10.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.  
Metric 1 [P-10.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Improvement Milestones and Metrics:**

**Milestone 8** [I-8.]: Integrated Services  
Metric 1 [I-8.1.]: X% of Individuals receiving both physical and behavioral health care at the established locations.  

**Milestone 9** [I-12.]: Improved Consumer satisfaction with Integrated Services  
Metric 1 [I-12.1.]: Metric: X% of People report satisfaction with integrated services
**Milestone 11 [I-9.]: Coordination of Care**

**Metric 1 [I-9.1.]:** X% of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise

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

This project addresses community needs CN.3 (Inadequate access to behavioral health care), CN.12 (High rates of tobacco use and excessive alcohol use), and CN.18 (Insufficient access to integrated care programs for behavioral health and physical health conditions).

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

This project represents a new initiative. UT Physicians does not currently provide behavioral health care at its 4 outlying (outside the TMC) clinics. UT Physicians will hire behavioral health providers to work with primary care providers to provide comprehensive and integrated care for patients in these 4 clinics, which serve areas that include large populations with economic, cultural, language, and transportation barriers to receiving care.

**Related Category 3 Outcome Measure(s):**

**OD-1 Primary Care and Chronic Disease Management**

- IT-1.8 Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) (Non-standalone measure)
  
  *Numerator:* Patient’s screening for clinical depression using a standardized tool AND follow-up plan is documented.

**OD-1 Primary Care and Chronic Disease Management**

- IT-1.9 Depression management: Depression Remission at Twelve Months (NQF# 0710) (Standalone measure)
  
  *Numerator:* Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.
  
  *Denominator:* Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine.

  *Exclusions:* Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.

**Relationship to other Projects:**

1.1 (C3) - Expanded primary care services will ensure there is reserve capacity to handle the increased collaboration necessary for integration physical health care with behavioral health care in the primary care setting.

1.2 (A2, SPH1) - Structured educational training for health care providers on team-based models of care will equip physicians and CHWs with the knowledge and skills to deliver this integrated model of care.

1.3 (C12) - The disease management registries will be a useful tool for the integrated care team in providing appropriate care for patients managing chronic diseases.

1.6 (C11) - The nurse triage line will provide 24/7 access to care for patients receiving both behavioral and physical health care.
1.7 (A1) - The telemedicine program will provide greater access for patients to their care providers (behavioral, primary and specialty care) when needed, particularly when distance is a barrier.

1.9 (C4) - The expansion of specialty services in the primary care setting will help to ensure that patients receiving integrated care will also have access to other specialty care when necessary in the same care setting.

2.1 (C1-2) - Patients receiving the integrated model of behavioral and physical health care will be enrolled in the UT Health Medical Homes.

2.2 (C5-9,CL3) - Patients with chronic diseases receiving the integrated model of behavioral and physical health care, will also received evidence-based care for their chronic disease. UTHealth will be using Wagner's chronic disease management model to manage chronic disease.

2.11 (C10) - The medication management program will be an integral component in the provision of integrated behavioral and physical health care.

**Relationship to Other Performing Providers’ Projects in the RHP:**

The cohabitation of primary care and behavioral health is an important focus of our region in order to treat the patient base with comprehensive physical and behavioral healthcare issues. There are multiple initiatives in our RHP plan that address this need and all can be found on the Region 3 Initiative Grid in the addendums. The outcome measures focused to screening measures and access of the patient base.

**Plan for Learning Collaborative:**

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

**Project Valuation:**

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. **Transformational Impact** (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. **Population Served/Project Size** (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.
3. **Aligned with Community Needs** (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. **Cost Avoidance** (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects.

5. **Partnership/Collaboration** (Weight = 10%): *This was not rated*, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. **Sustainability** (Weight = 15%): *This was also not rated*, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
### Related Category 3 Outcome Measure(s):

- **111810101.3.27**
- **111810101.3.28**

**IT-1.8**

- Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) (Non-standalone measure)
- Depression management: Depression Remission at Twelve Months (NQF# 0710) (Standalone measure)

### Year 2 (10/1/2012 – 9/30/2013)

**Milestone 1 [P-1.]:** Conduct needs assessment to determine areas of the state where the colocation of services has the potential to benefit a significant number of people who have physical/behavioral health needs.

**Metric 1 [P-1.1.]:** Numbers of patients in various areas who might benefit from integrated services: demographics, location, & diagnoses

**Baseline:** Currently there are no behavioral health services co-located in UTP primary care clinics

**Goal:** To complete a needs assessment that will identify the degree of need and areas where co-location of services will provide the greatest benefit.

**Data Source:** Inpatient, discharge and ED records; survey of primary care providers; survey of behavioral health providers; state demographic information relating to treated health conditions; Medicaid claims data

**Milestone 1 Estimated incentive payment:** $1,484,661

### Year 3 (10/1/2013 – 9/30/2014)

**Milestone 3 [P-5.]:** Develop integrated sites reflected in the number of locations and providers participating in the integration project

**Metric 1 [P-5.1.]:** Number of agreements signed for the provision of integrated services

**Goal:** Sign agreements to integrate services at clinics identified for co-location of services, based on DY2 assessments.

**Data Source:** Project data

**Milestone 3 Estimated incentive payment:** $1,116,286

### Year 4 (10/1/2014 – 9/30/2015)

**Milestone 6 [P-6.]:** Develop integrated behavioral health and primary care services within collocated sites.

**Metric 1 [P-6.1.]:** Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system).

**Goal:** Currently there is no such service integration in any of our clinics. The goal will be to achieve integrated behavioral/primary care services at 100% of clinics wherein services are co-located.

**Data Source:** Project data

**Milestone 6 Estimated incentive payment:** $1,160,938

### Year 5 (10/1/2015 – 9/30/2016)

**Milestone 7 [P-10.]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

**Metric 1 [P-10.1.]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Milestone 9 [I-12.]:** Improved Consumer satisfaction with Integrated Services

**Metric 1 [I-12.1.]:** Metric: X% of People report satisfaction with integrated services

**Goal:** A statistically significant increase at the 95% level over the previous reporting period for the behavioral health providers co-located in primary care clinics.

**Data Source:** Survey data from CAHPS

**Milestone 9 Estimated incentive payment:** $1,111,325

**Milestone 10 [P-10.]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

**Metric 1 [P-10.1.]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

**Milestone 10 Estimated incentive payment:** $1,111,325
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 2** [P-2.]: Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new settings or for physicians to share their office space with behavioral health practitioners.

**Metric 1** [P-2.1.]: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations. Goal: UTP primary care clinic physicians, and other community-based organizations will be interviewed about behavioral health needs for their patients and possibilities for co-locations of services to achieve an integrated model of care.

Data Source: Information from persons interviewed

Milestone 2 Estimated incentive payment: $1,116,286

**Milestone 4** Estimated incentive payment: $1,116,286

**Milestone 5** [P-3.]: Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa.

**Metric [P-3.1.]:** Number and types of referrals that are made between providers at the location. Goal: 70% of behavioral health referrals from a UTP primary care provider at the integrated clinics will be to the behavioral health provider practicing at that same clinic.

Data Sources: Review of referral data

Milestone 5 Estimated incentive payment: $1,116,286

**Milestone 7** Estimated incentive payment: $1,160,938

**Milestone 8** [I-8.]: Integrated Services

**Metric [I-8.1.]:** X% of Individuals receiving both physical and behavioral health care at the established locations. Goal: 25% of UTP patients needing behavioral health services.

Data Source: Project data; claims and encounter data; medical records

Milestone 8 Estimated incentive payment: $1,160,937

**Milestone 10** Estimated incentive payment: $1,111,324

**Milestone 11** [I-9.]: Coordination of Care

**Metric [I-9.1.]:** X% of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise. Goal: 70% of UTP patients that are receiving both primary and behavioral health care at the integrated clinics will have a treatment plan developed and implemented with primary care and behavioral health expertise.

Data Source: Project data; claims and encounter data; medical records

Milestone 10 Estimated incentive payment: $1,111,324

---

Regional Healthcare Partnership Plan

Region 3

1593
<table>
<thead>
<tr>
<th>111810101.2.7</th>
<th>2.15.1</th>
<th>A-J</th>
<th>INTEGRATED ADULT PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTHealth, UTPhysicians</td>
<td>111810101</td>
<td>Integrated Adult Primary and Behavioral Health Care Services</td>
<td></td>
</tr>
</tbody>
</table>

Related Category 3 Outcome Measure(s):

- 111810101.3.27
- 111810101.3.28
- IT-1.8
- IT-1.9

- Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) (Non-standalone measure)
- Depression management: Depression Remission at Twelve Months (NQF# 0710) (Standalone measure)

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

- Payment: $1,484,660
- Year 2 Estimated Milestone Bundle Amount: $2,969,321
- Year 3 Estimated Milestone Bundle Amount: $3,348,858
- Year 4 Estimated Milestone Bundle Amount: $3,482,813
- Year 5 Estimated Milestone Bundle Amount: $3,333,974

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $13,134,966
The University of Texas Health Science Center - Houston
Pass 3
**Project Option 2.15.1- 2.15 Integrate Primary and Behavioral Health Care Services:**

**Integrated Primary and Behavioral Health Care Services for Children and Adolescents**

**Unique RHP Project ID:** 111810101.2.8

**Performing Provider Name/TPI:** UTHealth, UTPhysicians / 111810101

**Project Summary:**

**Provider:** UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

**Intervention(s):** UT Health will design, implement and evaluate a project that will integrate primary and behavioral healthcare services for children and adolescents within UT Physicians’ clinics to achieve a close collaboration in a partly integrated system of care (Level IV). A pediatric behavioral health provider will be placed in the primary care setting to children and adolescents with behavioral health services at their usual source of health care. This will facilitate care coordination between primary and behavioral healthcare.

**Need for the project:** 20% of children either have, or will have a debilitating mental disorder and about 13% of children ages 8 to 15 had a diagnosable mental disorder within the previous year, though only half received any treatment. This project addresses several community needs including inadequate access to behavioral health care.

**Target Population:** The service areas of our 4 outlying clinics include health professional shortage areas, and medically underserved areas and populations. Using the Harris County rate (14.5%) of Medicaid clients, there are an estimated 1,423,176 Medicaid clients living within our service areas.

**Category 1 or 2 expected patient benefits:**
Based on the planned expanded capacity in pediatric behavioral health of this project, we expect to deliver approximately 5,760 counseling sessions and 3,600 psychiatry session per year, for a total of 9,360 behavioral health visits per year, once fully ramped up. By DY5, we expect to have completed approximately **24,000** behavioral health visits in an integrated program of primary care and behavioral health care. Of these, over **5,500** are expected to be Medicaid visits.

**Category 3 outcomes:**
Our goal is to improve patient quality of life (QOL) as measured by the evidence based and validated assessment tool, the 23-item PedsQL™ Generic Core questionnaire, for the target population (IT-10.1).
Project Option 2.15.1 – Integrate Primary and Behavioral Health Care Services: Integrated Primary and Behavioral Health Care Services for Children and Adolescents

Unique RHP Project Identification Number: 111810101.2.8
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 2.15 Integrate Primary and Behavioral Health Care Services (Option 2.15.1)

UT Health will design, implement and evaluate a project that will integrate primary and behavioral health care services for children and adolescents within UT Physicians 4 outlying clinics and the pediatric specialty clinic in the Texas Medical Center in order to achieve a close collaboration in a partly integrated system of care (Level IV). The project will recruit and place a pediatric behavioral health provider in the 4 primary care settings and the 1 pediatric specialty care clinic to provide children and adolescents with behavioral health services at their usual source of health care and will facilitate the coordination of care involving both primary and behavioral health. For the 4 outlying clinics, the project will focus on low behavioral health – low physical health complexity/risk (Quadrant I) and low behavioral health – high physical health complexity/risk (Quadrant III) of the Four Quadrant Model, which are most amendable to the primary care settings. Quadrants II and IV will be included with Quadrants I and III for the pediatric specialty care clinic in the Texas Medical Center. This project will be structured to achieve level 4 interaction (close collaboration in a partly integrated system, where providers share the same facility and share scheduling systems and medical records, and have regular face-to-face communication, functioning as a team), or preferably level 5 interaction (close collaboration in a fully integrated system, where providers are part of the same team and system and the patient experiences mental health treatment as part of their regular primary care or vice versa). The need for any legal agreements that may be needed in a collaborative practice will be explored for this project, and in addition necessary arrangements will be made for facilities to achieve this service integration.

Along with the co-location of services, protocols, training, and team building will be implemented to improve communications and enhance coordination of care to deliver care that meets the needs of the whole person. Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.

Goal and Relationship to Regional Goals:
Project Goal:
Integrate primary care and behavioral health care services in order to improve care and access to needed services.
This project addresses the following regional goal:

Provision of both physical and behavioral health services in one location will make care more accessible to patients in a convenient location, and this relates to one of the goals of the region which is to "develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction".

Challenges:

Need: 1) Insufficient access to integrated care programs for behavioral health and physical health conditions. 2) Inadequate access to behavioral health care. 3) High rates of tobacco use and excessive alcohol use.

Implementation: 1) Motivation and ability of primary care and behavioral health teams to work together. 2) Patient awareness about service availability.

Despite high indicators of need, parents of pediatric patients experience barriers in accessing behavioral health services, such as the stigma attached to mental health facilities and the inconvenience of adding another visit to their child’s health care regimen. The integration of pediatric behavioral and primary care in this project enables parents of pediatric patients to access coordinated efficient care in a convenient and less-stigmatized setting. Primary care providers will be trained to consult with and direct patients that may need behavioral health care services to the pediatric behavioral health provider. The pediatric behavioral health provider will have access to the patients records and be trained to consult with and direct patients to the primary care provider that may warrant further primary care services, or screenings. Parents of pediatric patients will be able to address both behavioral health needs and primary care needs in a single visit.

5-Year Expected Outcome for Provider and Patients:

Attainment of a level 4 or 5 integration level in primary care and behavioral health will help to achieve optimal patient outcomes. This will lead to increased screening and better management of depression and other behavioral health diagnoses in the population served by UT Physicians and better health overall.

Based on the planned expanded capacity in pediatric behavioral health of this project, we expect to deliver approximately 5,760 counseling sessions and 3,600 psychiatry session per year, for a total of 9,360 behavioral health visits per year, once fully ramped up. By DY5, we expect to have completed approximately 24,000 behavioral health visits in an integrated program of primary care and behavioral health care. Of these, over 5,500 are expected to be Medicaid visits. This is a very conservative estimate, because the growth in these clinics is expected to occur at a much higher payer mix for Medicaid than the current 23%.

Starting Point/Baseline:

There is currently no program in place for behavioral health services in any of our 4 community clinics and there is only one pediatric behavior health provider in our TMC pediatric specialty clinic. Baseline metrics and measures will be all-inclusive from the outset of the program as defined in the milestones table and the Category 3 outcomes table. Unique pediatric (ages 0-17) patients of UTP currently number 1,244 and only 5% (65) have any behavioral health diagnosis in the EMR.
Rationale:
According to the National Institute of Mental Health, 1 in 5 children (20%), either have, or will have a seriously debilitating mental disorder and data from the CDC’s National Health and Nutrition Examination Survey showed that about 13% of children ages 8 to 15 had a “diagnosable mental disorder within the previous year,” yet in the preceding year, only half had received treatment for their disorder. (Merikangas KR, He JP, Merikangas KR, He J, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J. Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A). J Am Acad Child Adolesc Psychiatry. 2010 Oct;49(10):980-989. http://www.nimh.nih.gov/statistics/1ANYDIS_CHILD.shtml) (Merikangas KR, He JP, Brody D, Fisher PW, Bourdon K, Koretz DS. Prevalence and treatment of mental disorders among US children in the 2001-2004 NHANES. Pediatrics. 2010, 125(1):75-81. http://www.nimh.nih.gov/statistics/1NHANES.shtml) By providing pediatric behavioral health services in the primary care setting, children and adolescents will be able to receive care that is more convenient for their parents (located within their community and in a clinic offering extended hours), coordinated (ability to address both conditions in a single visit), and in a setting that reduces the stigma surrounding behavioral health services, since it is located within the primary care setting.

Project Components:
Through the Integrated Primary and Behavioral Health Care Services Program, we propose to meet all required project components listed below.

a) UTP will identify sites for integrated care projects, which would have the potential to benefit a significant number of children/adolescents in the community.
b) UTP will develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated. UTP will also develop any necessary legal agreements that may be needed in a collaborative practice.
c) Also, protocols and processes for communication, data sharing, and referral between behavioral and physical health providers will be established that will include:
d) UTP will recruit specialty providers (pediatric mental health providers) and support staff to provide mental health services in the primary care clinics and in the pediatric specialty clinic.
e) UTP will train physical and behavioral health providers in protocols, effective communication and team approach.
   • Regular consultative meetings between physical health and behavioral health practitioners,
   • Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners, and/or
   • Shared treatment plans co-developed by both physical health and behavioral health practitioners.
f) UTP will acquire the necessary data reporting, communication and collection tools (equipment) to be used in the integrated setting.
g) UTP will develop any necessary legal agreements needed for a collaborative practice.
h) UTP will arrange for utilities and all other building services for the care settings.
UTP will develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individuals treated in these integrated service settings.

UTP’s quality improvement office will conduct QI for each of the clinics providing specialty care using methods such as rapid cycle improvement.

Milestones and Metrics:
For the Integrated Primary and Behavioral Health Care Services Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Milestones and Metrics:

Milestone 1 [P-1.]: Conduct needs assessment to determine areas of the state where the colocation of services has the potential to benefit a significant number of people who have physical/behavioral health needs.
Metric 1 [P-1.1.]: Numbers of patients in various areas who might benefit from integrated services: demographics, location, & diagnoses

Milestone 2 [P-2.]: Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new settings or for physicians to share their office space with behavioral health practitioners.
Metric 1 [P-2.1.]: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations.

Milestone 3 [P-5.]: Develop integrated sites reflected in the number of locations and providers participating in the integration project.
Metric 1 [P-5.1.]: Number of agreements signed for the provision of integrated services

Milestone 4 [P-5.]: Develop integrated sites reflected in the number of locations and providers participating in the integration project.
Metric 3 [P-5.3.]: Number of behavioral health providers newly located in primary care clinics.

Milestone 5 [P-3.]: Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa.
Metric [P-3.1.]: Number and types of referrals that are made between providers at the location

Milestone 6 [P-6.]: Develop integrated behavioral health and primary care services within colocated sites.
Metric 1 [P-6.1.]: Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system).

Milestone 7 [P-10.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.
Metric 1 [P-10.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

Milestone 9 [I-12.]: Improved Consumer satisfaction with Integrated Services
Metric 1 [I-12.1.]: Metric: X% of People report satisfaction with integrated services

**Milestone 10** [P-10.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

Metric 1 [P-10.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP

**Improvement Milestones and Metrics:**

**Milestone 8** [I-8.]: Integrated Services

Metric 1 [I-8.1.]: X% of Individuals (children/adolescents) receiving both physical and behavioral health care at the established locations.

**Milestone 11** [I-9.]: Coordination of Care

Metric 1 [I-9.1.]: X% of Individuals (children/adolescents) with a treatment plan developed and implemented with primary care and behavioral health expertise

**Unique community need identification numbers the project addresses:**

This project addresses community needs CN.3 (Inadequate access to behavioral health care) and CN.18 (Insufficient access to integrated care programs for behavioral health and physical health conditions).

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:**

This project represents a new initiative. UT Physicians does not currently provide pediatric behavioral health care at its 4 outlying (outside the TMC) clinics. UT Physicians will hire behavioral health providers to work with primary care providers to provide comprehensive and integrated care for pediatric patients in these 4 clinics and in the pediatric specialty clinic, which serve areas that include large populations with economic, cultural, language, and transportation barriers to receiving care.

**Related Category 3 Outcome Measure(s):**

IT-10.1 Quality of Life (Standalone measure)

Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.

Percent of pediatric patients ages 8-18, who are receiving both behavioral health and primary care in the integrated behavioral/primary care clinic setting for the previous 12 months, that show improvement in scores on the 23-item PedsQL™ Generic Core questionnaire.

Numerator: Patients from the denominator with improvement in scores on the 23-item PedsQL™ Generic Core questionnaire. Denominator: Patients 8-18 years of age as of the measurement year who received at least 12 months consecutive outpatient care for behavioral and primary care in the integrated clinic.

**Relationship to other Projects:**

1.1 (C3) - Expanded primary care services will ensure there is reserve capacity to handle the increased collaboration necessary for integration physical health care with behavioral health care in the primary care setting.
1.2 (A2, SPH1) - Structured educational training for health care providers on team-based models of care will equip physicians and CHWs with the knowledge and skills to deliver this integrated model of care.

1.3 (C12) - The disease management registries will be a useful tool for the integrated care team in providing appropriate care for patients managing chronic diseases.

1.6 (C11) - The nurse triage line will provide 24/7 access to care for patients receiving both behavioral and physical health care.

1.7 (A1) - The telemedicine program will provide greater access for patients to their care providers (behavioral, primary and specialty care) when needed, particularly when distance is a barrier.

1.9 (C4) - The expansion of specialty services in the primary care setting will help to ensure that patients receiving integrated care will also have access to other specialty care when necessary in the same care setting.

2.1 (C1-2) - Patients receiving the integrated model of behavioral and physical health care will be enrolled in the UT Health Medical Homes.

2.2 (C5-9, CL3) - Patients with chronic diseases receiving the integrated model of behavioral and physical health care, will also received evidence-based care for their chronic disease. UTHealth will be using Wagner's chronic disease management model to manage chronic disease.

2.11 (C10) - The medication management program will be an integral component in the provision of integrated behavioral and physical health care.

**Relationship to Other Performing Providers’ Projects in the RHP:**

The cohabitation of primary care and behavioral health is an important focus of our region in order to treat the patient base with comprehensive physical and behavioral healthcare issues. There are multiple initiatives in our RHP plan that addresses this need and all can be found on the Region 3 Initiative Grid in the addendums. The outcome measures focused to screening measures and access of the patient base.

**Plan for Learning Collaborative:**

UT Health will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

**Project Valuation:**

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project’s total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project’s total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UT Health used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:
1. **Transformational Impact** (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

2. **Population Served/Project Size** (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid.

3. **Aligned with Community Needs** (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses.

4. **Cost Avoidance** (Weight = 15%): Points were awarded based on judgment of project’s cost effectiveness relative to similar projects.

5. **Partnership/Collaboration** (Weight = 10%): *This was not rated*, because UT Health planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. **Sustainability** (Weight = 15%): *This was also not rated*, because UT Health does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.
<table>
<thead>
<tr>
<th>Milestone 1 [P-1.]: Conduct needs assessment to determine areas in our region where the co-location of services has the potential to benefit a significant number of children who have physical/behavioral health needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [P-1.1]: Numbers of patients in various areas who might benefit from integrated services: demographics, location, &amp; diagnoses Baseline: There are currently no pediatric behavior health services in any of our 4 community clinics, there is only one provider at our TMC pediatric specialty clinic Goal: To complete a needs assessment that will identify the degree of need and areas where co-location of services will provide the greatest benefit Data Source: Inpatient, discharge and ED records; survey of primary care providers; survey of behavioral health providers; state demographic information relating to treated health conditions; Medicaid claims data Milestone 1 Estimated incentive payment: $1,855,825</td>
</tr>
<tr>
<td>Milestone 3 [P-5.]: Develop integrated sites reflected in the number of locations and providers participating in the integration project Metric 1 [P-5.1.]: Number of agreements signed for the provision of integrated services Goal: Sign agreements to integrate services at clinics identified for co-location of services, based on DY2 assessments. At least one agreement will be executed with DePelchin Children’s Center to provide behavioral health services. Data Source: Project data Milestone 3 Estimated incentive payment: $1,395,359</td>
</tr>
<tr>
<td>Milestone 6 [P-6.]: Develop integrated behavioral health and primary care services within co-located sites. Metric 1 [P-6.1.]: Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system). Goal: Currently there is no such service integration in any of our clinics. The goal will be to achieve integrated behavioral/primary care services at 100% of clinics wherein services are co-located. Data Source: Project data Milestone 6 Estimated incentive payment: $1,451,172</td>
</tr>
<tr>
<td>Milestone 9 [I-12.]: Improved Consumer satisfaction with Integrated Services Metric 1 [I-12.1.]: Metric: X% of People report satisfaction with integrated services Goal: A statistically significant increase at the 95% level over the previous reporting period for the behavioral health providers co-located in primary care clinics. Data Source: Survey data from CAHPS Milestone 9 Estimated incentive payment: $1,389,156</td>
</tr>
<tr>
<td>Milestone 10 [P-10.]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-10.1.]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: At least 2 meetings per year</td>
</tr>
</tbody>
</table>
**Milestone 2 [P-2.]:** Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new settings or for physicians to share their office space with behavioral health practitioners.

**Metric 1 [P-2.1.]:** Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations.

Goal: Existing 4 clinics will be assessed for space to accommodate providers to address the needs for co-location of services in these clinics. Current clinic physicians will be interviewed about behavioral health needs for their patients. DePelchin Children’s Center will be consulted regarding this need and their capacity to provide contract services for this project.

Data Source: Meeting minutes,

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Project data</td>
<td>Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td>Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
</tr>
<tr>
<td>Milestone 4 Estimated incentive payment: $ 1,395,359</td>
<td>Milestone 5 Estimated incentive payment: $ 1,451,172</td>
<td>Milestone 10 Estimated incentive payment: $ 1,389,156</td>
<td>Milestone 11 Estimated incentive payment: $ 1,389,156</td>
</tr>
</tbody>
</table>

**Milestone 5 [P-3.]:** Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa.

**Metric 3 [P-3.1.]:** Number and types of referrals that are made between providers at the location

Goal: 70% of behavioral health referrals from a UTP primary care provider at the integrated clinics will be to the behavioral health provider practicing at that same clinic.

Data Sources: Review of referral data

Milestone 5 Estimated incentive payment: $ 1,395,359

**Milestone 8 [I-8.]:** Integrated Services

**Metric 1 [I-8.1.]:** X% of Individuals (children/adolescents) receiving both physical and behavioral health care at the established locations.

Baseline: 0 (new program)

Goal: 70% of UTP pediatric patients (children/adolescents) needing behavioral health services.

Data Source: Project data; claims and encounter data; medical records

Milestone 8 Estimated incentive payment: $ 1,451,172
<table>
<thead>
<tr>
<th>111810101.3.34</th>
<th>IT-10.1</th>
<th>Quality of Life-PedsQL (Standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>111810101</strong></td>
<td><strong>UTHealth, UTPhysicians</strong></td>
<td><strong>111810101</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>111810101.3.34</th>
<th>IT-10.1</th>
<th>Quality of Life-PedsQL (Standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td>interviews, and other project documents</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Milestone 2 Estimated incentive payment: $ 1,855,825

Year 2 Estimated Milestone Bundle Amount: $3,711,650

Year 3 Estimated Milestone Bundle Amount: $4,186,076

Year 4 Estimated Milestone Bundle Amount: $4,353,516

Year 5 Estimated Milestone Bundle Amount: $4,167,468

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $16,418,710
University of Texas M.D. Anderson Cancer Center
Pass 1
Project Option 2.7.1 – Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.): Colorectal cancer (CRC) screening program for low-income residents of RHP3.

Unique RHP Project ID: 112672402.2.1

Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402

Project Summary:
Provider: The University of Texas MD Anderson Cancer Center is a comprehensive cancer center ranked first in cancer care by U.S. News & World Report and dedicated to patient care, education, research and prevention. MD Anderson is comprised of several Texas Medical Center campus locations, two research campuses in Bastrop County, Texas, four regional care centers and a number of national and international divisions and affiliates. More than 108,000 people—almost one-third of them new patients—were seen in FY2011. MD Anderson provided $215 million in uncompensated charity care to Texans in FY2011. This project does not receive funding from, nor does it advance any federal initiatives pertaining to, CMS Innovation Center Grants, HITECH payments, HRSA grants, SAMHSA funding and CDC (immunization grants or CLASBI/ Hospital acquired infection) grants.

Intervention(s): This project will expand a two-year Colorectal Cancer (CRC) screening program in Federally Qualified Health Centers (FQHCs) in Harris County into other RHP3 counties. This project targets low-income and underinsured populations with the intent of increasing adherence by distributing Fecal Immunochemical Test (FIT) take-home tests at the time of annual flu inoculation. Patients will receive a FIT test with verbal and written instructions on how to complete the test, brief verbal messages reinforcing the importance of screening (e.g., “an annual FOBT (FIT) test is as important as an annual flu shot”), educational materials, and clinic phone numbers should questions arise.

Need for the project: A) This program relates to the identified Community Needs in RHP3: CN.2-Inadequate access to specialty care; CN.11-High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with cancer; CN.20-Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs; CN.22-Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities; CN.23-Lack of patient navigation, patient and family education and information programs. B) There is a multi-county need as data from the 2010 Behavioral Risk Factor Surveillance indicates that in Public Health Administrative Region 6/5S, only 38.6% of adults 50 years and older reported having ever had a sigmoidoscopy or colonoscopy in the past 5 years, and 13.9% reported annual fecal occult blood testing. This is well below the ACS’ 2015 goal of 75% of all adults over 50 having a recent CRC screening test.

Target Population: Indigent and Medicaid patients, aged 50 years and older, who, in accordance with the U.S. Preventive Services Task Force recommendations, qualify for CRC screening.

Category 1 or 2 expected patient benefits: The DY4 goal is to increase the number in the target population receiving FIT by 5% over DY3. The DY5 goal is to increase number of target population receiving FIT by 5% over DY4.

Category 3 outcomes: IT-12.3: Colorectal Cancer Screening (HEDIS 2012): Number of adults aged 50 -75 who have received one of the following screenings: Fecal occult blood test yearly, flexible sigmoidoscopy every five years, and colonoscopy every 10 years.
IT-12.6 Other Outcome Improvement Target: Flu vaccination status for adults age 50 – 75. IT-12.6 Other Outcome Improvement Target: Increase in adherence to annual flu vaccination and colorectal cancer screening guidelines in Medicaid and indigent population age 50 to 75
Project Option 2.7.1 – Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.): Colorectal cancer (CRC) screening program for low-income residents of RHP3

Unique RHP Project Identification Number: 112672402.2.1  
Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402

Project Description:  
We propose to implement a FIT-Flu program in RHP3 targeting low-income and underinsured populations with the intent of increasing adherence with this screening method.

We selected the FIT test because it requires less patient preparation compared with FOBT. An evidence-based intervention developed by Dr. Michael Potter at the University of California at San Francisco (UCSF), the FIT/Flu combines the distribution of either FOBT or FIT tests with annual flu inoculations. The FIT test analyzes specific antibodies to human blood components, and thus does not require patients to follow any dietary or medication restrictions. The FIT-Flu intervention involves offering patients who undergo annual flu inoculations a stool test to take home and return via mail in a postage-paid envelope.

This intervention has demonstrated significant increases in screening adherence across diverse patient populations and settings. Study settings included community clinics that served multiethnic and low income populations with low baseline CRC screening rates, as well as retail chain pharmacies where flu shots are typically offered. In a study involving annual flu shot clinics, there was a significant increase in FIT adherence over baseline in the FIT-Flu intervention group (from 54.4% to 84.3%) versus a control group that received only CRC screening education (from 52.9% to 57.3%). More modest increases in adherence were achieved in a study involving primary care clinics, with the intervention group increasing from 32.5% to 45.5% versus the control group which rose from 31.3% to 35.6%.

The success of this intervention may be attributed to even this brief interaction between clinician and patient at the time of flu inoculation, as it offers a “teachable moment” to reinforce the need for regular screening. Studies provide consistent evidence that a FIT-Flu intervention is a practical strategy with high potential to increase CRC screening adherence in community clinic settings. Furthermore, evidence generated by these studies indicates a strong likelihood of successful replication in real world, non-controlled settings.

This project expands a currently ongoing two year FIT/Flu initiative in Federally Qualified Health Centers (FQHCs) in Harris County in other RHP3 counties. We will reach indigent and Medicaid patients, age 50 years and older, who, in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations, qualify for CRC screening. Our exclusion criteria include the following:

- Allergic to flu vaccine or refusal to receive a flu inoculation
- Active inflammatory bowel disease (Crohn’s, ulcerative colitis)
- Visible rectal bleeding
- Hematuria
- Menstruation at the time of obtaining a stool specimen
• A positive FOBT or FIT test in the past 12 months
• A colonoscopy or sigmoidoscopy within the past 5 years
• A medical condition that would preclude any benefit from OC (cancer or any terminal illness)
• Inability to prepare a stool specimen
• Patient with an ileostomy or colostomy
• Symptomatic acute colitis or acute diarrhea
• Recent acute diverticulitis
• Recent colorectal surgery

Patients in our project will receive a FIT with verbal and written instructions on how to complete the test, brief verbal messages reinforcing the importance of screening (e.g., “an annual FOBT (FIT) test is as important as an annual flu shot”), educational materials, and clinic phone numbers should questions arise. We anticipate receiving 50% return of stool specimens for processing, of which approximately 15% (published ranges of 8-14%) may be positive. Patients with positive FIT tests will be referred for optical colonoscopy. Endoscopy providers will be contracted to provide these services. Uninsured individuals diagnosed with cancer will be navigated to Harris Health Systems or other providers.

Goal(s) and Relationship to Regional Goal(s):

The goal of this project is utilize an evidence based approach in RHP3 FQHC clinics and other primary care offices to increase CRC screening and annual flu vaccination by distributing the take-home FIT test at the time of flu inoculation. Patient Navigators will follow-up those patients who do not return the FIT to encourage them to do so and will navigate those patients with positive FIT results to screening colonoscopy. Culturally sensitive educational and instructional materials will be distributed to increase patient knowledge about CRC and the importance of early screening. We will partner with the American Cancer Society (ACS) to offer professional education and support material to assist primary care physicians in providing appropriate CRC screening recommendations to their patient population.

Project Goals:

• Reduce the incidence and mortality of colorectal cancer in the indigent and Medicaid population through the increased use of a low-cost stool test for the early detection of adenomas and cancers.
• Increase target population’s knowledge about the risk factors and screening guidelines for CRC.
• Increase the use of appropriate CRC screening in the primary care setting.
• Increase annual flu vaccination.
• Increase patient returns for annual flu vaccination and CRC screening.

This project meets the following Region 3 goals:

• Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

The FIT-Flu program aims to reduce the incidence and mortality of colorectal cancer by offering a process to dispense CRC screening in the primary care setting. This project will be implemented in FQHCs in RHP3 and is an extension of an existing program in Harris County FQHCs. This project does not receive funding from, nor does it advance any federal initiatives.
pertaining to, CMS Innovation Center Grants, HITECH payments, HRSA grants, SAMHSA funding and CDC (immunization grants or CLASBI/ Hospital acquired infection) grants.

Challenges:

According to the Agency for Healthcare Research and Quality (AHRQ), only about half of all adults aged 50-75 have ever received age-appropriate colorectal cancer (CRC) screening, and the proportion of minority populations who have ever been screened is reported to be approximately 30%. The Texas Cancer Registry indicates that 44.5% of adults reported having sigmoidoscopy or colonoscopy in the past 5 years, and 14.1% reported annual FOBT. Various public education campaigns and strategies have been attempted to increase CRC screening rates in the underserved and underinsured populations, but poor adherence with stool tests, especially in the uninsured, remains a significant barrier to effective CRC screening.

Barriers to CRC screening reported by patients include practical issues such as being too busy, a lack of access to providers, the cost of the exam, being asymptomatic, embarrassment, and fear of finding polyps or cancer. Other important barriers to implementing CRC screening in primary care practice settings include patients’ lack of awareness of their risk for developing CRC and/or a lack of knowledge of screening options, particularly among poor and underserved populations. Incomplete follow-up of positive FOBT results is another issue, as primary care physicians often fail to recommend optical colonoscopy to patients with positive FOBT results.

The challenge of improving CRC screening adherence is even greater in large primary care practices, where time and resource limitations reduce the likelihood that physicians are able to adequately discuss CRC screening with their patients. In a study by Wolf, only 9% of age-eligible patients at thirty-one Federally Qualified Health Centers (FQHCs) received a CRC screening recommendation from their physician and only 7% were adherent to screening, primarily through FOBT. Difficulties cited include prioritization, time, resources, complexity of referral, and perceived acceptance of screening tests. This project will include a culturally sensitive educational program on CRC for patients, as well as professional training on the importance and appropriate use of CRC screening in a primary care setting.

5-Year Expected Outcome for Provider and Patients:

It is expected that this project in DY2 – DY5 would serve a total of 6,405 patients with 13,292 unique services:

- Increase the use of FIT as first-line CRC screening in the primary care setting.
- Increase patient knowledge regarding colorectal cancer incidence and available screening tools.
- Increase appropriate use of CRC screening modalities in primary care practice.

The breakdown is as follows:

- DY2: 100 provided FIT screening kits; 8 served with colonoscopy
- DY3: 2000 served with FIT screening; 150 served with colonoscopy
- DY4: 2100 provided FIT screening kits and flu vaccination; 158 served with colonoscopy
- DY5: 2205 provided FIT screening kits and flu vaccination; 166 served with colonoscopy

- Increase annual flu vaccination in primary care practice.
- DY2: 100 served with flu vaccination
o DY3: 2000 served with flu vaccination
o DY4: 2100 served with flu vaccination
o DY5: 2205 served with flu vaccination

- Increase patient compliance in return visits for flu vaccination and CRC screening through utilization of provider reminders.
  - DY4: 315 of the 2100 provided FIT screening kits and flu vaccination will be returning patients for annual services
  - DY5: 331 of the 2205 provided FIT screening kits and flu vaccination will be returning patients for annual services

**Starting Point/Baseline:**
There is a multi-county need as data from the 2010 Behavioral Risk Factor Surveillance indicates that in Public Health Administrative Region 6/5S, only 38.6% of adults 50 years and older reported having ever had a sigmoidoscopy or colonoscopy in the past 5 years, and 13.9% reported annual fecal occult blood testing. This is well below the ACS’ 2015 goal of 75% of all adults over 50 having a recent CRC screening test. Due to the seasonal offering of flu vaccination, the baseline of 100 will be established during one month distributing FIT tests at the time of flu vaccination in DY2.

**Rationale/Reason for selecting the program option:**
CRC screening has been shown to save lives. Screening prevalence is lower among people aged 50 to 64 compared to those 65 years and older, and is especially low among those who are non-white, who have fewer years of education, who lack health insurance coverage, and who are recent immigrants. The 2010 National Healthcare Quality and Disparities Report indicates that Hispanics/Latinos undergo CRC screening at rates lower than African Americans and Whites, and thus are at great risk for presenting with late-stage disease at diagnosis. Improving CRC screening in clinics serving indigent and Medicaid patients is a priority need, as these clinics are the primary source of care for a disproportionately high number of African American and Hispanic/Latino patients. Low levels of knowledge about this topic have been linked with inaccurate CRC risk perceptions and low utilization of screening services. The primary reason patients do not return FOBTs is that they do not believe they need screening if they have no symptoms of CRC. These data underscore the need to implement innovative screening strategies.

**Project Components:**
Through the FIT-Flu Program, we propose to meet all required project components listed below and believe that the selected milestones and metrics relate to the project components:
- Increase recommended CRC screening by means of an evidence based process to reach eligible patients unscreened for CRC and by offering professional education to assist primary care physicians in providing appropriate CRC screening recommendations to their patient population.
- Establish collaborative partnerships with community organizations to ensure culturally competent patient education materials are disseminated and evidence based health professional training is utilized.
• Educate patients on the risk factors and screening recommendations for CRC.
• Increase access to CRC screening.
• Conduct quality improvement using methods evaluate the ongoing effectiveness of the program.

Milestones & Metrics:
The following milestones and metrics have been chosen for the FIT-Flu Project based on the needs of the target population.

- Process Milestones and Metrics: P-7(P-7.1, P-7.2); P-X (P-X.1, P-X.2, P-X.3, P-X.4, P-X.5, P-X.6)
- Improvement Milestones and Metrics: I-X (I-X.1)
- Customizable Process Milestones and Metrics were chosen to specifically tailor their intent to the project process.

Unique community need identification number the project addresses:
The project addresses the following unique community needs, as identified in the community needs assessment:

- CN.2 Inadequate access to specialty care.
- CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including cancer, diabetes obesity, cardiovascular disease, asthma, and AIDS/HIV.
- CN.20 Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs.
- CN.22 Insufficient access to services that are specifically designed to address racial, ethnic and cultural health disparities.
- CN.23 Lack of patient navigation, patient and family education and information programs.

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
This project will expand an existing FIT/Flu initiative in Federally Qualified Health Centers (FQHCs) in Harris County, extending this project into other RHP3 counties not currently served by this initiative. Additionally, the existing Harris County project would be included in DY4 and DY5, extending this project an additional two years.

Related Category 3 Outcome Measure(s):
OD-12 Primary Care and Primary Prevention
IT-12.3 Colorectal Cancer Screening (HEDIS 2012)
  Numerator: The number of Medicaid and indigent adults aged 50 to 75 who receive one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, and colonoscopy every 10 years
  Denominator: The number of eligible Medicaid and indigent adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.

IT-12.6 Other Outcome Improvement Target: Flu vaccination status for adults age 50 – 75.
Numerator: Number of eligible Medicaid and indigent adults age 50 – 75 vaccinated for flu
Denominator: Number of Medicaid and indigent patients age 50 – 75 in patient population eligible for flu vaccination

IT-12.6 Other Outcome Improvement Target: Increase in adherence to annual flu vaccination and colorectal cancer screening guidelines in Medicaid and indigent population age 50 to 75
Numerator: Number of return Medicaid and indigent patients for annual flu and CRC screening
Denominator: Number of Medicaid and indigent patients reminded of annual screening and flu vaccination

Reasons/Rationale for selecting the outcome measure(s):
CRC can be curable if detected in its early stages, but often fatal when diagnosed later. According to the Surveillance, Epidemiology and End Results (SEER) Program, patients diagnosed with Stage 1 disease (localized to the bowel wall) have a 90.1% 5-year survival rate compared to those with Stage 4 disease (distant metastases) who have an 11.7% 5-year survival rate. Similar data are found in Texas with localized CRC showing an 88.1% 5-year survival and distant disease yielding a 13.2% 5-year survival. CRC screening has been shown to save lives. The United States Preventive Services Task Force (USPSTF) recommends the following CRC screening options for persons age 50-75 who are at average risk for the disease: (1) annual fecal occult blood testing (FOBT) using high-sensitivity stool guaiac tests or fecal immunochemical tests (FIT), (2) flexible sigmoidoscopy every 5 years plus FOBT or FIT every three years, or (3) optical colonoscopy every 10 years.

Morbidity and mortality from influenza are “potentially preventable” by utilization of annual influenza immunization through appropriate outpatient healthcare. In 2010, the Advisory Committee on Immunization Practices (ACIP) first recommended annual influenza vaccination for all persons aged ≥6 months in the United States and annual influenza vaccination of all persons aged ≥6 months continues to be recommended. Reminders inform health care providers it is time for a client’s cancer screening test and annual influenza immunization or that the client is overdue for screening. The reminders can be provided in different ways, such as in client charts or by e-mail. The Community Preventive Services Task Force recommends provider reminder systems based on strong evidence of their effectiveness in increasing adherence to annual screening recommendations.

Relationship to Other Projects:
This project reinforces and extends an existing colorectal screening project of the Colorectal Cancer Workgroup, which is one of eight focus areas in the Comprehensive Cancer Control initiative in the Houston MSA.

Relationship to Other Performing Providers’ Projects in the RHP:
The increase of primary care and specialty care will naturally result in additional ambulatory care encounters for our region patient base. The ambulatory initiatives cover items such as laboratory, PT/OT, social work, etc. and are a necessity of our patients to ensure a
comprehensive treatment for access as well as cost avoidance. The Region 3 initiative grid in the addendum reflects all ambulatory operations initiatives.

**Plan for Learning Collaborative:**
We will participate in face-to-face learning such as meetings or seminars with other providers and the RHP, at least twice per year to promote collaborative learning around shared or similar projects. At each face-to-face meeting, we will collaborate to identify performance improvements and will ensure that these suggested improvements will be incorporated into our project processes.

**Project Valuation:** We have based our project valuation on California’s 1115 Medicaid Waiver model. As such, we have valued our projects at 2.5 times that of the estimated costs. Basing our valuations on California’s calculations we know we are well within the potential range of future cost savings when looking at the following from Prevention Institute and Trust for America’s Health Issue Report entitled *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities (July 2008):*

- Prevention can reduce end-of-life costs by increasing health during the lifespan, what researchers call the *compression of morbidity*.
- There is a substantial return-on-investment in prevention – For every $1 invested in community-based prevention, the return amounts to $5.60.
### PROJECT TITLE: IMPLEMENT INNOVATIVE EVIDENCE-BASED STRATEGIES TO INCREASE APPROPRIATE USE OF TECHNOLOGY AND TESTING FOR TARGETED POPULATIONS (E.G., MAMMOGRAPHY SCREENS, COLONOSCOPIES, PRENATAL ALCOHOL USE, ETC.): COLORECTAL CANCER SCREENING PROGRAM FOR LOW-INCOME RESIDENTS OF RHP3

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center  
**TPI – 112672402**

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Metric 1 [P-X.1]: Number of project staff hired.</th>
</tr>
</thead>
</table>
|                    |                      | a. **Baseline:** 0  
|                    |                      | b. **Goal:** 3  
|                    |                      | c. **Data source:** Institutional position descriptions  
|                    |                      | d. **Rationale/Evidence:** Staff hired to develop and execute project implementation plan.  
|                    |                      | Metric 2 [P-X.2]: Document implementation strategies.  
|                    |                      | a. **Baseline/Goal:** Produce comprehensive manual outlining strategies for implementation of project.  
|                    |                      | b. **Data Source:** Performing Provider contract(s), clinic EMR, position descriptions, HIPAA guidelines, and other documentation of implementation as developed by Performing Provider.  

| Year 2  
(10/1/2012 – 9/30/2013) | Year 3  
(10/1/2013 – 9/30/2014) | Year 4  
(10/1/2014 – 9/30/2015) | Year 5  
(10/1/2015 – 9/30/2016) |
|-------------------------|------------------------|------------------------|------------------------|
| **Milestone 1 [P-X]**  
Develop program infrastructure for innovative FIT/Flu CRC screening project for Medicaid and indigent patient population in RHP 3.  
Metric 1 [P-7.1]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.  
Metric 2 [P-7.1]: Participate in semiannual face-to-face meetings or seminars organized by the RHP.  
Baseline/Goal: Baseline of 0; Goal of 2 per year  
Data Source: Documentation of semiannual meetings including meeting agendas and slides from presentations, and/or meeting notes.  
Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote | **Milestone 6 [P-7]**: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.  
**Milestone 7 [P-7]**: Participate in semiannual face-to-face meetings or seminars organized by the RHP.  
Baseline/Goal: Baseline of 0; Goal of 2 per year  
Data Source: Documentation of semiannual meetings including meeting agendas and slides from presentations, and/or meeting notes.  
Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote | **Milestone 8 [P-7]**: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.  
**Milestone 9 [P-7]**: Participate in semiannual face-to-face meetings or seminars organized by the RHP.  
Baseline/Goal: Baseline of 0; Goal of 2 per year  
Data Source: Documentation of semiannual meetings including meeting agendas and slides from presentations, and/or meeting notes.  
Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote | **Milestone 10 [P-7]**: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.  
**Milestone 11 [P-7]**: Participate in semiannual face-to-face meetings or seminars organized by the RHP.  
Baseline/Goal: Baseline of 0; Goal of 2 per year  
Data Source: Documentation of semiannual meetings including meeting agendas and slides from presentations, and/or meeting notes.  
Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote |
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

c. **Rationale/Evidence:** Documentation of implementation guidelines ensure uniform practices.  

**Metric 3 [P-X.3]** Develop training manuals for project staff.  
Baseline: 0 Goal: Produce comprehensive training curricula and manual for project staff  
Data Source: Completed manual.  
Rationale/Evidence: Development of training ensures that staff follow uniform procedures and practices as outlined in implementation documentation.

c. **Rationale/Evidence:** Development of training ensures that staff follow uniform procedures and practices as outlined in implementation documentation.  

**Metric 4 [P-X.4]** Develop training manual for clinic staff.  
Baseline: 0 Goal: Produce comprehensive training curricula and manual for project staff  
Data Source: Completed manual.  
Rationale/Evidence: Training ensures compliance with project guidelines and reporting requirements.  

**Continuous Learning and Exchange Between Providers and Decide Collectively How to “Raise the Floor”**  
For performance across all providers.

**Metric 2 [P-7.2]** Implement the “raise the floor” improvement initiatives established at the semiannual meeting.  
Baseline: 0 Goal: Produce comprehensive training curricula and manual for project staff  
Data Source: Documentation of the “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the “raise the floor” improvement initiative after the semiannual meeting.  
Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” and “raise the bar” for performance across providers.  

**Metric 2 [P-7.2]** Implement the “raise the floor” improvement initiatives established at the semiannual meeting.  
Baseline: 0 Goal: Produce comprehensive training curricula and manual for project staff  
Data Source: Documentation of the “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the “raise the floor” improvement initiative after the semiannual meeting.  
Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” and “raise the bar” for performance across providers.
**PROJECT TITLE:** Implement Innovative Evidence-based Strategies to Increase Appropriate Use of Technology and Testing for Targeted Populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.): Colorectal Cancer Screening Program for Low-income Residents of RHP3

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**Related Category 3 Outcome Measure(s):**
- 112672402.3.1 IT-12.3 IT-12.6 IT-12.6
- 112672402.3.2
- 112672402.3.3

**Outcome Measure(s):**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
a. Baseline: 0 Goal: 1  
b. Data Source: Database  
b. Rationale/Evidence: A database ensures timely reporting and follow-up as well as accurate and timely reporting.  
| Milestone 6 Estimated Incentive Payment (maximum amount): $1,210,614.50  
Improvement Milestone 7 [I-X]: Increase adoption of FIT/Flu guidelines in RHP3 FQHCs and clinics.  
Metric 1 [I-X.1]: Evidence of changes in provider practice norms as evidenced by increased adherence to CRC screening and flu vaccination guidelines by providers as well as by patients  
a. Baseline: 0 clinics; Goal: 5 clinics  
b. Data Source: Clinic EMR records, written and telephonic documentation of correspondence with patients.  
| Milestone 8 Estimated Incentive Payment (maximum amount): $1,161,254.00  
Improvement Milestone 9 [I-X]: Increased adherence to FIT/Flu guidelines in RHP 3 FQHCs and clinics.  
Metric 1 [I-X.1]: Evidence of changes in provider practice norms as evidenced by increased adherence to CRC screening and flu vaccination guidelines by providers as well as by patients  
a. Baseline: 5 clinics; Goal: 8 clinics  
b. Data Source: Clinic EMR records, written and telephonic documentation of correspondence with patients.  
| Milestone 10 Estimated Incentive Payment (maximum amount): $1,327,824.00  
Improvement Milestone 11 [I-X]: Increased adherence to FIT/Flu guidelines in RHP 3 FQHCs and clinics.  
Metric 1 [I-X.1]: Evidence of changes in provider practice norms as evidenced by increased adherence to CRC screening and flu vaccination guidelines by providers as well as by patients  
a. Baseline: 8 clinics; Goal: 12 clinics  
b. Data Source: Clinic EMR records, written and telephonic documentation of correspondence with patients.  
| Milestone 11 Estimated Incentive Payment (maximum amount): $1,327,824.00  

Milestone 1 Estimated Incentive Payment ($274,907.40)

Milestone 2 [P-X] Develop contact methodology between patient and...
### PROJECT TITLE: IMPLEMENT INNOVATIVE EVIDENCE-BASED STRATEGIES TO INCREASE APPROPRIATE USE OF TECHNOLOGY AND TESTING FOR TARGETED POPULATIONS (E.G., MAMMOGRAPHY SCREENS, COLONOSCOPY, PREGNATAL ALCOHOL USE, ETC.): COLORECTAL CANCER SCREENING PROGRAM FOR LOW-INCOME RESIDENTS OF RHP3

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**TPI – 112672402**

**Related Category 3 Outcome Measure(s):**
- 112672402.3.1
- 112672402.3.2
- 112672402.3.3

**IT-12.3**
**IT-12.6**
**IT-12.6**

**Colorectal Cancer Screening (HEDIS 2012)**

**Other Outcome Improvement Target:** Flu vaccination status for adults age 50 – 75

**Other Outcome Improvement Target:** Increase in compliance with annual flu vaccination and colorectal cancer screening.

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**TPI – 112672402**

**Related Category 3**
**Outcome Measure(s):**
- 112672402.3.1
- 112672402.3.2
- 112672402.3.3

**IT-12.3**
**IT-12.6**

**Colorectal Cancer Screening (HEDIS 2012)**

**Other Outcome Improvement Target:** Flu vaccination status for adults age 50 – 75

**Other Outcome Improvement Target:** Increase in compliance with annual flu vaccination and colorectal cancer screening.

Metric 1 [P-X.1] Implement a recall system that allow staff to report which patients are due for annual CRC screening and flu vaccination and track when and how patients are notified.

a. Data Source: Documentation of recall report

b. Rationale/Evidence: The goal of this milestone is to make evidence-based care routine. This is accomplished through both planned interactions initiated by the practice, and through point-of-care reminders which help ensure that every interaction is informed by the clinical needs and wishes of the patient. This means that the availability of up-to-date patient information is key, as well as the care team’s ability to review patient data before the visit and communicate via team healthcare to encourage increased adherence to FIT/Flu guidelines in RHP 3 FQHCs and clinics.
### Project Title: Implement Innovative Evidence-Based Strategies to Increase Appropriate Use of Technology and Testing for Targeted Populations (e.g., Mammography Screens, Colonoscopies, Prenatal Alcohol Use, etc.): Colorectal Cancer Screening Program for Low-Income Residents of RHP3

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**RHP PP Reference Number:** 2.7.1

**Project Components:** 2.7.1

---

**Related Category 3 Outcome Measure(s):**

- 112672402.3.1
- 112672402.3.2
- 112672402.3.3

**Outcome Measure(s):**

- IT-12.3
- IT-12.6

**Colorectal Cancer Screening (HEDIS 2012)**

**Other Outcome Improvement Target:** Flu vaccination status for adults age 50 – 75

**Other Outcome Improvement Target:** Increase in compliance with annual flu vaccination and colorectal cancer screening.

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 2 Estimated Incentive Payment** ($274,907.40)

**Milestone 3 [P-X]:** In DY2 establish a baseline of Medicaid and indigent patients eligible to receive FIT or FOBT for CRC screening and flu vaccination.

**Metric 1 [P-X.1]:** Review of eligible patient demographics by clinic.
- Baseline/Goal: Baseline 0; Goal 100
- Data Source: Individual clinic EMR

**Milestone 3 Estimated Incentive Payment** (maximum amount): ($274,907.40)

**Milestone 4 [P-X]:** Develop culturally sensitive promotional and educational materials.

**Metric 1: [P-X.1]** Production of fliers, posters and brochures in English, Spanish, Chinese and Vietnamese.
<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Cancer Screening (HEDIS 2012)</td>
<td>Colorectal Cancer Screening (HEDIS 2012)</td>
<td>Colorectal Cancer Screening (HEDIS 2012)</td>
<td>Colorectal Cancer Screening (HEDIS 2012)</td>
<td>Colorectal Cancer Screening (HEDIS 2012)</td>
</tr>
<tr>
<td>Other Outcome Improvement Target: Flu vaccination status for adults age 50 – 75</td>
<td>Other Outcome Improvement Target: Flu vaccination status for adults age 50 – 75</td>
<td>Other Outcome Improvement Target: Flu vaccination status for adults age 50 – 75</td>
<td>Other Outcome Improvement Target: Flu vaccination status for adults age 50 – 75</td>
<td>Other Outcome Improvement Target: Flu vaccination status for adults age 50 – 75</td>
</tr>
<tr>
<td>Other Outcome Improvement Target: Increase in compliance with annual flu vaccination and colorectal cancer screening.</td>
<td>Other Outcome Improvement Target: Increase in compliance with annual flu vaccination and colorectal cancer screening.</td>
<td>Other Outcome Improvement Target: Increase in compliance with annual flu vaccination and colorectal cancer screening.</td>
<td>Other Outcome Improvement Target: Increase in compliance with annual flu vaccination and colorectal cancer screening.</td>
<td>Other Outcome Improvement Target: Increase in compliance with annual flu vaccination and colorectal cancer screening.</td>
</tr>
</tbody>
</table>

**Baseline:** 0  
**Goal:** 7000 flyers/posters; 10,000 brochures

**Data Source:** Completed flyers, posters and brochures.

**Rationale/Evidence:** The Community Preventive Services Task Force recommends interventions that use small media based on strong evidence of their effectiveness in increasing colorectal cancer screening by fecal occult blood test (FOBT).

**Milestone 4 Estimated Incentive Payment (maximum amount):** ($274,907.40)

**Milestone 5 [P-7.1]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should
**PROJECT TITLE:** IMPLEMENT INNOVATIVE EVIDENCE-BASED STRATEGIES TO INCREASE APPROPRIATE USE OF TECHNOLOGY AND TESTING FOR TARGETED POPULATIONS (E.G., MAMMOGRAPHY SCREENS, COLONOSCOPIES, PRENATAL ALCOHOL USE, ETC.): COLORECTAL CANCER SCREENING PROGRAM FOR LOW-INCOME RESIDENTS OF RHP3

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Metric 1 [P-7.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

- **Baseline/Goal:** Baseline of 0; Goal of 2 per year
- **a. Data Source:** Documentation of semiannual meetings including meeting agendas and slides from presentations, and/or meeting notes.
- **b. Rationale/Evidence:** Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” for performance across all providers.

**Metric 2 [P-7.2]:** Implement the “raise the floor” improvement initiatives established at the semiannual meeting.

- **a. Data Source:** Documentation of the “raise the floor” improvement initiatives agreed upon at each
**UNIQUE IDENTIFIER:** 112672402.2.1  
**RHP PP REFERENCE NUMBER:** 2.7.1  
**PROJECT COMPONENTS:** 2.7.1  

**PROJECT TITLE:** IMPLEMENT INNOVATIVE EVIDENCE-BASED STRATEGIES TO INCREASE APPROPRIATE USE OF TECHNOLOGY AND TESTING FOR TARGETED POPULATIONS (E.G., MAMMOGRAPHY SCREENS, COLONOSCOPIES, PRENATAL ALCOHOL USE, ETC.): COLORECTAL CANCER SCREENING PROGRAM FOR LOW-INCOME RESIDENTS OF RHP3

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center  
**TPI – 112672402**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>112672402.3.1</td>
<td>IT-12.3</td>
<td>IT-12.6</td>
<td>IT-12.6</td>
<td></td>
</tr>
<tr>
<td>112672402.3.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>112672402.3.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Colorectal Cancer Screening (HEDIS 2012)  
Other Outcome Improvement Target: Flu vaccination status for adults age 50 – 75  
Other Outcome Improvement Target: Increase in compliance with annual flu vaccination and colorectal cancer screening.

**Year 2 Estimated Milestone Bundle Amount:** ($1,374,537.00)  
**Year 3 Estimated Milestone Bundle Amount:** $2,421,229.00  
**Year 4 Estimated Milestone Bundle Amount:** $2,322,508.00  
**Year 5 Estimated Milestone Bundle Amount:** $2,655,648.00

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**: ($8,773,922.00)

*semiannual meeting and documentation that the participating provider implemented the “raise the floor” improvement initiative after the semiannual meeting*  
*b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” and “raise the bar” for performance across providers.  
Milestone 5 Estimated Incentive Payment (maximum amount): ($274,907.40)*
Project Option 2.7.2 – Implement innovative evidence-based strategies to reduce tobacco use – Evidence-Based Smoking Cessation Program for Underserved Persons Living with HIV/AIDS

Unique RHP Project ID: 112672402.2.2
Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402

Project Summary:
Provider: The University of Texas MD Anderson Cancer Center is a comprehensive cancer center ranked first in cancer care by *U.S. News & World Report* and dedicated to patient care, education, research and prevention. MD Anderson is comprised of several Texas Medical Center campus locations, two research campuses in Bastrop County, Texas, four regional care centers and a number of national and international divisions and affiliates. More than 108,000 people—almost one-third of them new patients—were seen in FY2011. MD Anderson provided $215 million in uncompensated charity care to Texans in FY2011.

Intervention(s): This project will implement an evidence-based smoking cessation program for persons living with HIV/AIDS at the Legacy Community Health Services sites. Legacy provides care to approximately 40,000 underserved individuals (including 4,000 individuals living with HIV/AIDS) at five clinic sites in the greater Houston area. Legacy is also a nationally recognized leader in HIV/AIDS care. Smoking represents the leading cause of preventable death among persons living with HIV/AIDS. By implementing procedures for routine smoking screening and offering an evidence-based smoking cessation program, this project will fill an important gap for the underserved population served by Legacy.

Need for the project:
- This project addresses Community Needs: CN.6: Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly; CN.11: High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease including: cancer, diabetes, obesity, cardiovascular disease, asthma, and AIDS/HIV; CN.12 – High rates of tobacco use and excessive alcohol use.

- A wide range of studies have documented dramatically elevated rates of current smoking in HIV-positive populations, generally two to three times higher than the prevalence of smoking in the general population. Recent evidence indicates that smoking cessation among person with HIV could reduce the risk of overall mortality by almost 16%; reduce the risk of a major cardiovascular disease event by 20%; and reduce the risk of non-AIDS malignancies by 34%.

Target Population: One thousand patients living with HIV/AIDS will be enrolled in the smoking cessation program. While current smoking prevalence data are not available for the Legacy patient population, the estimated prevalence is 50%. This estimate is based on extensive existing literature documenting high smoking rates in this population. (Estimates range from 50 to 70%).

Category 1 or 2 expected patient benefits: The DY3 goal is to enroll 50% (n=500) of program eligible smokers into smoking cessation services. The DY4 goal is to enroll 50% (n=500) of program eligible smokers. The DY5 goal is to disseminate the cell phone smoking cessation intervention to HIV care centers located throughout the RHP.

Category 3 outcomes:
IT-11.6: Other Outcome Improvement Target (Quit Attempts) – 75% (n=750) of enrollees in the smoking cessation program will make a successful quit attempt.
- DY3: n=187 will make a successful quit attempt
- DY4: n=375 will make a successful quit attempt
- DY5: n=188 will make a successful quit attempt

**IT-11.6:** Other Outcome Improvement Target (Smoking Cessation/Staying Quit) – 25% of smokers (n=250) will be abstinent at the time of the 6-month follow-up
- DY3: n=62 will be abstinent at the time of the 6-month follow-up
- DY4: n=125 will be abstinent at the time of the 6-month follow-up
- DY5: n=63 will be abstinent at the time of the 6-month follow-up

**IT-11.3:** Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity (Screening for Cigarette Smoking) – 4000 HIV positive patients will be screened for current smoking
- DY3: n=2000 HIV positive patients will be screened for current smoking
- DY4: n=2000 HIV positive patients will be screened for current smoking
Project Option 2.7.2 – Implement innovative evidence-based strategies to reduce tobacco use - Evidence-Based Smoking Cessation Program for Underserved Persons Living with HIV/AIDS

Unique RHP Project Identification Number: 112672402.2.2
Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402

Project Description:
The goal of the current proposal is to adapt, implement, and evaluate an evidence-based, cell phone-delivered smoking cessation treatment program targeted to low-income and underinsured individuals living with HIV/AIDS. The proposed smoking cessation project will involve a partnership with Legacy Community Health Services – a large, Federally Qualified Health Center (FQHC).

Program overview. In the first phase of our project, we will train Legacy staff to: 1) screen for current smoking, 2) identify eligible HIV+ smokers 3) offer smoking cessation treatment to eligible participants, and 4) administer the cessation intervention. Active recruitment will begin in phase 2. Participants who enroll in the program will meet with their HIV Case Manager and treatment materials (call calendar and nicotine replacement patches) will be dispersed. The final phase of the project will consist of follow-up assessment and dissemination to other HIV care centers in the RHP.

Treatment overview. Enrollees will be given brief advice to quit smoking and offered nicotine replacement therapy (NRT) in the form of nicotine patches. Enrollees will then receive a series of proactive telephone counseling sessions that will be conducted over a six month time period. This evidence-based treatment approach is based on the United States Public Health Service (USPHS) Guidelines and our previous work with HIV+ smokers.1-3 Extensive evidence supports the efficacy of NRT. We have chosen to use nicotine patches due to their ease of use and low risk of side effects. When combined with provider advice to quit smoking, NRT effectively doubles the odds of successfully quitting.2 For the phone counseling component, we have chosen to use the approach developed in our earlier clinical trial. Counseling session content is primarily drawn from cognitive-behavioral and motivational interviewing techniques. Importantly, content is tailored to the individual’s HIV status, and addresses HIV-specific issues.

Assessments, which will include smoking status measures, psychosocial measures, and process variables, will be conducted in the Legacy clinics at the time of program enrollment, and at 3- and 6-months post enrollment. After all program participants have completed the 6-month follow-up, a detailed program evaluation will be conducted.

Community Partner. For this project, we will partner with Legacy Community Health Services. Legacy provides care to approximately 40,000 underserved individuals (including 4,000 individuals living with HIV/AIDS) at five clinic sites in the greater Houston area. Legacy is also a nationally recognized leader in HIV/AIDS care. Providers (intake nurses and case managers/social workers) at the clinic sites will assist with screening and smoking cessation intervention delivery. We have a strong record of this type of collaboration as evidenced by our previous research initiatives at Thomas Street Health Center of the Harris Health System.
Goal(s) and Relationship to Regional Goals(s):

Aim 1: Adapt a previously developed smoking cessation treatment approach for use with Legacy Community Health Service’s HIV+ patient population.

*Our goal is to work with Legacy staff to adapt our proactive cell phone counseling intervention so that program implementation will minimize clinic flow disruption, while appealing to a majority of the target population. If successful, our program will be readily implemented, maintained, and administered by the Legacy clinic sites and, ultimately, disseminable to other HIV-care centers across the RHP.*

Aim 2: Implement an evidence-based smoking cessation program for persons living with HIV/AIDS at the Legacy clinic sites.

*Our goal is to screen, enroll, and provide smoking cessation treatment (consisting of brief provider advice to quit, nicotine replacement therapy, and proactive phone counseling) to 1000 smokers receiving HIV care at the 5 Legacy clinic sites.*

Aim 3: Evaluate the effectiveness of the smoking cessation program implemented at Legacy.

*Our goal is to evaluate the following:

- **Reach** of the smoking cessation program - defined as the proportion of identified HIV-positive smokers who enroll in the program.
- **Efficacy** of the program - defined as the proportion of smokers who successfully quit smoking.
- **Implementation** of the program – defined as: 1) proportion of Legacy patients screened for program eligibility; 2) proportion of scheduled counseling calls completed by Case Managers; 3) dose of counseling treatment per participant (proportion of scheduled calls); and 4) dose of nicotine replacement therapy (NRT) per participant (proportion of NRT patches used).
- **Costs** – cost analysis, cost-effectiveness analysis, and cost utility analysis of the treatment program will be performed.*

Regional Goal. This proposed project is responsive to the first regional goal, “Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health outcomes and patient satisfaction.” At the present time, Legacy Community Health Services (an FQHC providing care to the underserved population in the greater Houston area) does not systematically screen smoking status, or offer smoking cessation services. Thus, the proposed project will fill an important gap. An existing evidence-based treatment will be offered to HIV+ smokers, while non-HIV+ positive smokers will be referred to the Texas Quitline. Moreover, the treatment provided to the HIV+ smokers will be administered through the HIV Case Management service already in place at Legacy.

Challenges:

Major challenges of the project include the following: 1) obtaining buy-in from staff at Legacy, 2) overcoming barriers to smoking cessation treatment, and 3) offering a sustainable program. We have carefully considered each of these challenges in the design of the project. First, buy-in will be facilitated by the support we have already received from Legacy Leadership. Specifically, Dr. Richard Beech, Chief Medical Officer, strongly supports this program and is fully committed to our initiative. Also, a key collaborator on this project, Dr. Leonard Zwelling, Professor, Experimental Therapeutics at MD Anderson Cancer Center serves on the Board of Directors at Legacy. Thus, he will be able to facilitate communications between project investigators and
Legacy leadership. Second, the design of the project itself overcomes many barriers to treatment commonly experienced by underserved HIV+ smokers. Key program elements, such as use of cell phones for treatment delivery, use of NRT (vs. other medications), and eliminating extra clinic visits, are each designed to minimize barriers, potential hazards, and overall participant burden. Third, a crucial component of the project is the training of case managers to deliver and administer the cessation program. Thus, the personnel resources will remain after the funding for the program ends. In addition, the program will ultimately be appropriate for a large number of HIV care centers.

5-Year Expected Outcome for Provider and Patients:
We believe our program will result in: 1) enhanced screening for smoking, 2) promote the delivery of evidence-based smoking cessation treatment, 3) promote quit attempts among participants receiving treatment, 4) reduce the prevalence of current smoking, and ultimately 5) reduce morbidity and mortality of smoking-related malignancies in the HIV-positive population.

Starting Point/Baseline: Patients will be recruited from the population of individuals receiving care at the Legacy Community Health Services, a Federally Qualified Health Center with a national reputation as a leader in HIV/AIDS prevention and treatment. Legacy provides care to approximately 40,000 patients, including more than 4,000 persons living with HIV/AIDS. Currently, smoking status is not systematically assessed, nor is cessation treatment offered. The HIV+ patient population is racially/ethnically diverse (33% Black/African American; 33% White; and 26% Hispanic). Approximately 70% of the patients are male, and 78% are between the ages of 25 and 54 years. Finally, 47% of the population is gay or bisexual and 44% are heterosexual.

We plan to enroll 1000 patients in the smoking cessation program. While current smoking prevalence data are not available for the Legacy patient population, we estimate a prevalence of 50%. This estimate is based on the extensive existing literature documenting high smoking rates in this population (estimates ranging from 50 to 70%),4-8 as well as anecdotal reports from Legacy clinic staff (“at least 50% of the patients smoke”). We estimate, conservatively, that 50% of the HIV/AIDS patients screened at the Legacy clinics will be current smokers (that is 2000 of the 4000 HIV+ patients treated at Legacy). We would, therefore, need to enroll approximately 50% of these patients to reach our target of 1000. Given our ability to consistently enroll approximately 66% of smokers in our previous and ongoing studies with HIV+ smokers, a goal of 50% in the proposed program is readily achievable. In addition, non-HIV positive smokers will be referred to the Texas Quitline.

Rationale:
Cigarette smoking among persons living with HIV/AIDS represents a significant public health problem. A wide range of studies have documented dramatically elevated rates of current smoking in HIV-positive populations, generally two to three times higher than the prevalence of smoking in the general population.4,6-8 Recent evidence indicates that smoking cessation among persons with HIV could reduce the risk of overall mortality by almost 16%; reduce the risk of a major cardiovascular disease event by 20%; and reduce the risk of non-AIDS malignancy by 34%.9 Despite the high prevalence of current smoking and the substantial health benefits offered by smoking cessation treatment, surprisingly few efforts to deliver cessation treatment to this population appear in the literature.10
In previous efforts, Dr. Vidrine and colleagues have developed and performed efficacy assessments of behavioral interventions consisting of proactive cell phone-delivered smoking cessation counseling for HIV+ smokers. Findings from these efforts indicate that this treatment approach significantly increases abstinence rates over usual care (see preliminary evidence section) in the HIV-positive population. Despite the positive findings, much room for program dissemination and treatment improvement exists.

Several key factors were considered in the design of the proposed smoking cessation program. First, the proposed intervention (brief advice to quit, proactive cell phone counseling + NRT) builds on a solid, evidence-based foundation. This intervention has yielded positive results in earlier studies targeting underserved persons with HIV. Moreover, the efficacy of proactive phone counseling interventions and NRT have been extensively established in the general population. Second, the proposed intervention successfully overcomes many barriers to other interventions. For example, barriers such as limited transportation, housing instability, treatment costs, lack of landline/internet access, and limited literacy will not prevent participation in the proposed program. Finally, we have chosen to offer NRT as a component of the treatment. NRT is effective and offers several advantages over other potential pharmacotherapies (i.e., bupropion and varenicline), including fewer potential interactions with antiretroviral medications and less risk of psychiatric side effects. NRT is also available at no (or greatly reduced) cost to Legacy patients.

**Project Components:**
We believe our program will result in: 1) enhanced screening for smoking [P-X], 2) promote the delivery of evidence-based smoking cessation treatment [P-2], 3) promote quit attempts among participants receiving treatment [P-X], 4) reduce the prevalence of current smoking [IT-11.1], and ultimately 5) reduce morbidity and mortality of smoking-related malignancies in the HIV-positive population [IT-11.6, IT-11.3].

**Milestones & Metrics:**
The following milestones and metrics have been chosen for the Smoking Cessation Program for Underserved Persons Living with HIV/AIDS:
- Process Milestones and Metrics: P-X (P-X.1, P-X.2); P-1 (P-1.1); P-2 (P-2.1); P-3 (P-3.1); P-7 (P-7.1, P-7.2)
- Improvement Milestones and Metrics: I-5 (1-5.1); OD-11 (IT-11.1, IT-11.6, IT-11.3)

**Unique community need identification number the project addresses:**
The project addresses the following unique community needs as identified in the community needs assessment:
- CN.6 – Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly
- CN.11 – High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease including: cancer, diabetes, obesity, cardiovascular disease, asthma, and AIDS/HIV
- CN.12 – High rates of tobacco use and excessive alcohol use

**How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:**
An innovative component of our program is the use of case managers as program stakeholders. HIV case management is a client-focused process that delivers, expands, and coordinates
services to clients. Generally stated, the ultimate goal of HIV case management is to help patients achieve better levels of physical, emotional, and social functioning. The literature indicates that HIV case management can result in a number of improved health outcomes, particularly for individuals with complex health care needs, including improved quality of life. Therefore, offering smoking cessation counseling fits well within the mission of the case management discipline. In addition, input from clinical staff at Legacy indicated that an intervention that utilizes the already established case management service would be ideal. Finally, because case management is available in most HIV clinics, our approach may have higher dissemination potential than alternative approaches. For example, The Ryan White Care Act currently provides funding to more than 2500 organizations, and case management services to more than 500,000 HIV-positive individuals.

**Related Category 3 Outcome Measure(s):**

**IT-11.6:** Other Outcome Improvement Target (Quit Attempts) – 75% (n=750) of enrollees in the smoking cessation program will make a successful quit attempt

- DY3: n=187 will make a successful quit attempt
- DY4: n=375 will make a successful quit attempt
- DY5: n=188 will make a successful quit attempt

**IT-11.6:** Other Outcome Improvement Target (Smoking Cessation/Staying Quit) – 25% of smokers (n=250) will be abstinent at the time of the 6-month follow-up

- DY3: n=62 will be abstinent at the time of the 6-month follow-up
- DY4: n=125 will be abstinent at the time of the 6-month follow-up
- DY5: n=63 will be abstinent at the time of the 6-month follow-up

**IT-11.3:** Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity (Screening for Cigarette Smoking) – 4000 HIV positive patients will be screened for current smoking

- DY3: n=2000 HIV positive patients will be screened for current smoking
- DY4: n=2000 HIV positive patients will be screened for current smoking
- DY5: n=2000 HIV positive patients will be screened for current smoking

**Reasons/rationale for selecting the outcome measure(s):**

Several important factors support our choice of OD-11 as our category 3 outcome domain. First, HIV/AIDS is among the conditions with the greatest disparities in health services and quality. Education, income, and employment status, along with race/ethnicity have been identified as important independent predictors of HIV/AIDS status. For instance, AIDS incidence and mortality are disproportionately high among African American and Hispanic individuals. African Americans and Hispanics account for approximately one quarter of the total U.S. population; however, these same two groups account for more than two thirds of the reported cases of AIDS. This translates to a rate among African Americans that is more than 8 times higher than the rate for whites, and the rate for Hispanics is 3 times higher compared to whites. Therefore, reducing the disproportionate impact of HIV/AIDS among traditionally underserved populations and improving health outcomes for people living with HIV/AIDS are national priorities.

A second important consideration is high prevalence of current smoking among people living with HIV/AIDS. Numerous reports describing dramatically elevated rates of smoking (40-70%) in this special population appear in the scientific literature. There are several characteristics that are known to be associated with both smoking status and HIV serostatus. Education level, income, and employment status have been identified as important independent predictors of both HIV/AIDS and smoking status. Certain behavioral and psychosocial
variables (e.g., sexual orientation, heavy alcohol consumption, illicit drug use, and depressive symptoms) are also associated with both smoking status and HIV/AIDS. While smoking is a hazardous behavior for all populations, HIV+ individuals appear to be particularly susceptible to the adverse health effects of tobacco use. In addition to increasing the risk of various pulmonary conditions and oral infections, smoking significantly elevates the risk of cancer among individuals with HIV. For example, anal, cervical, and lung cancers are observed significantly more often among HIV+ smokers compared to nonsmokers.

Despite the high prevalence of smoking and the increased risk of numerous adverse health outcomes, efforts to deliver cessation treatment to persons living with HIV/AIDS are rare. In fact, our community partner for the proposed project serves one of the largest HIV+ patient populations in the state, yet currently has no smoking cessation program available to these patients. Therefore, offering an evidence-based cessation program presents the potential to reduce smoking prevalence in the Legacy patient population, resulting in fewer smoking-related diseases and poor health outcomes.

Relationship to Other Projects: By delivering an evidenced-based smoking cessation program to the underserved population of HIV+ smokers at Legacy Community Health Services, this program is in line with the RHP. This project also supports our other projects in that they all support one of the eight goals of the Comprehensive Cancer Control Program at The University of Texas MD Anderson Cancer Center.

Relationship to Other Performing Providers’ Projects in the RHP: Innovation is key to the transformation of healthcare in our community. The consistency of innovation in our region allows for increased improvements based on research trends, patient need, and provider availability. The waiver funding allows for innovation in specific areas and all innovative projects included in the plan are similar in the fact of program redesigns for historic treatments, and focus to chronic condition outcome measures such as central line infections. The Region 3 initiative grid in the addendum can provide a side by side comparison of all projects that directly relate to innovation.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for RHP3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

Project Valuation: We have based our project valuation on California’s 1115 Medicaid Waiver model. As such, we have valued our projects at 2.5 times that of the estimated costs. Basing our valuations on California’s calculations we know we are well within the potential range of future cost savings when looking at the following from Prevention Institute and Trust for America’s Health Issue Report entitled Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities (July 2008):

- Prevention saves money – an investment of $10 per person per year in programs to increase physical activity, improve nutrition, and prevent tobacco use could save the country more than $16 billion in annual health care costs within five years.
• Prevention can reduce end-of-life costs by increasing health during the lifespan, what researchers call the *compression of morbidity*.

There is a substantial return-on-investment in prevention – For every $1 invested in community-based prevention, the return amounts to $5.60.
### Project Title: Implement innovative evidence-based strategies to reduce tobacco use - Evidence-Based Smoking Cessation Program for Underserved Persons Living with HIV/AIDS

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**TPI - 112672402**

**Related Category 3**

**Outcome Measure(s):**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1 [P-X]**

**Metric [P-X.1]:** Develop a detailed manual of procedures.

**Baseline/Goal:** Baseline - Currently, smoking cessation is not documented systematically. Goal – Work with staff at Legacy to produce a detailed manual of procedures to standardize the assessment and documentation of smoking status.

**Data Source:** Completed manual of procedures

**Milestone 6 [P-2]:** Implement evidence-based innovative project for targeted population

**Metric [P-2.1]:** Document implementation strategy and testing outcomes; Enroll and deliver treatment to 50% (n=500) of eligible HIV+ smokers screened at Legacy.

**Baseline/Goal: 0/500**

Baseline- Presently, Legacy does not offer a smoking cessation program. Goal - We will enroll 50% (n=500) of the eligible smokers screened.

**Data Source:** Primary data collection to be recorded in medical records and program databases.

**Rationale:** These efforts will help to solidify all aspect of the smoking cessation treatment program. Specifically, these efforts will solidify the integration of screening, enrollment, treatment, follow-up, data collection, and date transfer.

**Milestone 6 Estimated Incentive Payment:** $609,637.00

**Milestone 7 [P-7]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year

**Milestone 8 [P-2]:** Implement evidence-based innovative project for targeted population

**Metric [P-2.1]:** Document implementation strategy and testing outcomes; Enroll and deliver treatment to 50% (n=500) of eligible HIV+ smokers screened at Legacy.

**Baseline/Goal: 500/500**

Baseline – It is estimated that 500 participants will be enrolled in the smoking cessation program at the beginning of DY4. Goal - We will enroll 50% (n=500) of the eligible smokers screened by the end of DY4.

**Data Source:** Primary data collection to be recorded in medical records and program databases.

**Rationale:** These efforts will help to solidify all aspect of the smoking cessation treatment program. Specifically, these efforts will solidify the integration of screening, enrollment, treatment, follow-up, data collection, and date transfer.

**Milestone 8 Estimated Incentive Payment:** $318,950.00

**Milestone 9 [P-3]:** Execution of learning and diffusion strategy for testing, spread and sustainability

**Metric [P-3.1]:** Document the dissemination of cell phone smoking cessation intervention; Disseminate the cell phone smoking cessation intervention to HIV care centers located throughout the RHP.

**Baseline/Goal: 0/5**

Baseline - Presently, we are unaware of any HIV care centers in the region that systematically screen for smoking and offer treatment. Goal - we will reach out to other HIV care centers (n=5) providing medical care to underserved populations across the region. We will offer training and assistance with the cessation program implementation.

**Data Source:** previous developed training materials, procedures, treatment materials, and program databases.

**Rationale:** Smoking among underserved patients with HIV/AIDS represents the leading cause of mortality. The effort to target this growing population with tailored and
**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**Project Title:** Implement innovative evidence-based strategies to reduce tobacco use - Evidence-Based Smoking Cessation Program for Underserved Persons Living with HIV/AIDS

<table>
<thead>
<tr>
<th>UNIQUE IDENTIFIER:</th>
<th>RHP PP REFERENCE NUMBER:</th>
<th>PROJECT COMPONENTS:</th>
<th>Project Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>112672402.2.2</td>
<td>2.7.2</td>
<td>2.7.2</td>
<td>Implement innovative evidence-based strategies to reduce tobacco use - Evidence-Based Smoking Cessation Program for Underserved Persons Living with HIV/AIDS</td>
</tr>
</tbody>
</table>

**Unique Identifier:** 112672402.3.4, 112672402.3.5, 112672402.3.6

**IT-11.6**

Other Outcome Improvement Target: (Quit Attempts)
Other Outcome Improvement Target: (Staying Quit)
Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity (Screening for Cigarette Smoking)

**UNIQUE IDENTIFIER:** 112672402.3.4
**RHP PP REFERENCE NUMBER:** 2.7.2

**PROJECT COMPONENTS:**
- IT-11.6
- IT-11.6
- IT-11.3

**Related Category 3 Outcome Measure(s):**
- Tobacco use - Evidence-Based Smoking Cessation Program for Underserved Persons Living with HIV/AIDS

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>

**Baseline/Goal:** Our previously developed cell phone delivered cessation treatment will serve as the baseline. Our goal is to adapt and further develop this program for use with Legacy patients.

**Data Source:** Input from Legacy staff, project investigators, and the scientific literature.

**Rationale:** It is vital that we work closely with Legacy staff on the smoking cessation treatment manual. This effort will ensure that 1) the content areas addressed are appropriate and 2) the time needed to deliver the intervention is feasible.

**Milestone 1 Estimated Incentive Payment:** $245,896.60

**Baseline/Goal:** 0/2 per year

**Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

**Rationale:** These meetings will help to improve our efforts to efficiently reach and treat our target population of HIV positive smokers.

**Milestone 2 [P-1]: Development of innovative evidence-based project for targeted population**

**Metric [P-1.1] Document innovative strategy and plan; Finalize treatment components e.g., smoking cessation treatment manual.**

**Baseline/Goal:** 0/2 per year

**Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

**Rationale:** These meetings will help to improve our efforts to efficiently reach and treat our target population of HIV positive smokers.

**Milestone 3 [P-2]: Implement the “raise the floor” improvement initiatives established at the semiannual meeting.**

**Baseline/Goal:** 0/Goal of 100% of agreed upon improvement initiatives

**Milestone 4 [P-7]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.**

**Baseline/Goal:** 0/Goal of 100% of agreed upon improvement initiatives

**Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

**Rationale:** These meetings will help to improve our efforts to efficiently reach and treat our target population of HIV positive smokers.

**Milestone 9 [P-7]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.**

**Baseline/Goal:** 0/Goal of 100% of agreed upon improvement initiatives

**Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

**Rationale:** These meetings will help to improve our efforts to efficiently reach and treat our target population of HIV positive smokers.

**Metric (P-7.2) Implement the “raise the floor” improvement initiatives established at the semiannual meeting.**

**Baseline/Goal:** 0/Goal of 100% of agreed upon improvement initiatives

**Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

**Rationale:** These meetings will help to improve our efforts to efficiently reach and treat our target population of HIV positive smokers.

**Milestone 10 Estimated Incentive Payment:** $147,592.20

**Milestone 11 [P-7]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.**

**Baseline/Goal:** 0/Goal of 100% of agreed upon improvement initiatives

**Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

**Rationale:** These meetings will help to improve our efforts to efficiently reach and treat our target population of HIV positive smokers.

**Metric (P-7.2) Implement the “raise the floor” improvement initiatives established at the semiannual meeting.**

**Baseline/Goal:** 0/Goal of 100% of agreed upon improvement initiatives

**Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

**Rationale:** These meetings will help to improve our efforts to efficiently reach and treat our target population of HIV positive smokers.

**Metric (P-7.1) Participate in semi-annual face-to-face meetings or seminars organized by the RHP.**

**Baseline/Goal:** 0/2 per year

**Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

**Rationale:** These meetings will help to improve our efforts to efficiently reach and treat our target population of HIV positive smokers.

**Metric (P-7.1) Participate in semi-annual face-to-face meetings or seminars organized by the RHP.**

**Baseline/Goal:** 0/2 per year

**Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.

**Rationale:** These meetings will help to improve our efforts to efficiently reach and treat our target population of HIV positive smokers.
**Unique Identifier:** 112672402.2.2

**RHP PP Reference Number:** 2.7.2

**Project Components:** 2.7.2

**Project Title:** Implement innovative evidence-based strategies to reduce tobacco use - Evidence-Based Smoking Cessation Program for Underserved Persons Living with HIV/AIDS

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**TPI - 112672402**

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Project Components:</th>
</tr>
</thead>
<tbody>
<tr>
<td>112672402.3.4</td>
<td>IT-11.6</td>
</tr>
<tr>
<td>112672402.3.5</td>
<td>IT-11.6</td>
</tr>
<tr>
<td>112672402.3.6</td>
<td>IT-11.3</td>
</tr>
</tbody>
</table>

- Other Outcome Improvement Target: (Quit Attempts)
- Other Outcome Improvement Target: (Staying Quit)
- Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity (Screening for Cigarette Smoking)

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>

Ultimately, these efforts will improve both the sustainability and efficacy of the intervention.

**Milestone 2 Estimated Incentive Payment:** $245,896.60

**Milestone 3 [P-X]:** Conduct training sessions with Legacy staff (case managers and other providers).

**Metric [P-X.1]:** Document training sessions

**Baseline/Goal:** Our goal is to train staff on the proper delivery of brief advice to quit smoking, and on the conduct of the proactive telephone sessions, which includes both CBT and MI components. Staff will also be trained on the appropriate use of NRT.

**Rationale:** This training will provide the staff with the expertise needed to deliver the smoking cessation intervention.

**Data Source:** Previously developed training materials, as well as input from Legacy staff, project investigators, and the scientific literature.

**Milestone 3 Estimated Incentive Payment:** $609,636.83

**Milestone 7 Estimated Incentive Payment:** $609,637.00

**Milestone 9 Estimated Incentive Payment:** $318,950.00

**Milestone 11 Estimated Incentive Payment:** $147,592.33

**Milestone 12:** [I-5] Identify X number of patients in defined meeting agendas, slides from presentations, and/or meeting notes.

**Rationale:** These meetings will help to improve our efforts to efficiently reach and treat our target population of HIV positive smokers.

**Metric (P-7.2):** Implement the “raise the floor” improvement initiatives established at the semiannual meeting.

**Baseline/Goal:** 0/Goal of 100% of agreed upon improvement initiatives

**Data Source:** Documentation of “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the “raise the floor” improvement initiative after the semiannual meeting.

**Rationale:** Implantation of the improvement initiatives will help to improve our smoking cessation program.

**Milestone 9 Estimated Incentive Payment:** $318,950.00

**Milestone 11 Estimated Incentive Payment:** $147,592.33
**Project Title:** Implement innovative evidence-based strategies to reduce tobacco use - Evidence-Based Smoking Cessation Program for Underserved Persons Living with HIV/AIDS

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

<table>
<thead>
<tr>
<th>Related Category 3 Outcome Measure(s):</th>
<th>Project Components:</th>
<th>Project Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>112672402.3.4</td>
<td>IT-11.6</td>
<td>Other Outcome Improvement Target: (Quit Attempts)</td>
</tr>
<tr>
<td>112672402.3.5</td>
<td>IT-11.6</td>
<td>Other Outcome Improvement Target: (Staying Quit)</td>
</tr>
<tr>
<td>112672402.3.6</td>
<td>IT-11.3</td>
<td>Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity (Screening for Cigarette Smoking)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment:</strong> $245,896.60</td>
<td><strong>Baseline/Goal:</strong> Presently, Legacy does not offer a smoking cessation program. Our goal is to identify current smokers and offer them evidence-based treatment. <strong>Data Source:</strong> Primary data collection and program databases. <strong>Rationale:</strong> These efforts will help to solidify all aspects of the smoking cessation treatment program. Specifically, these efforts will solidify the integration of screening, enrollment, treatment, follow-up, data collection, and data transfer. <strong>Milestone 4 Estimated Incentive Payment:</strong> $245,896.60</td>
<td><strong>Rationale:</strong> HIV-positive smokers are a high risk yet underserved population. Thus, our efforts to disseminate our treatment approach to members of this population throughout the region fills a pressing public health need. <strong>Milestone 12 Estimated Incentive Payment:</strong> $147,592.33</td>
<td><strong>Rationale:</strong> These efforts will help to solidify all aspects of the smoking cessation treatment program. Specifically, these efforts will solidify the integration of screening, enrollment, treatment, follow-up, data collection, and data transfer. <strong>Milestone 5 [P-7]: Participate in population receiving innovative intervention consistent with evidence-based model.</strong> Metric [I-5.1]: Estimated number of HIV-positive smokers receiving evidence-based cessation treatment Baseline/Goal: 0/500 Baseline - At the beginning of DY5, it is estimated that no HIV-positive smokers (other than those already enrolled in our program) will be receiving the cell phone-based treatment. Goal – By the end of DY5, we estimate that an additional 500 participants will be enrolled. <strong>Date Source:</strong> Documentation of target population reached. <strong>Rationale:</strong> HIV-positive smokers are a high risk yet underserved population. Thus, our efforts to disseminate our treatment approach to members of this population throughout the region fill a pressing public health need. <strong>Milestone 12 Estimated Incentive Payment:</strong> $147,592.33</td>
</tr>
</tbody>
</table>

**Payment:** $245,896.60

**Milestone 4 [P-2]: Implement evidence-based innovational project for targeted population**

**Metric [P-2.1] Document implementation strategy and testing outcomes; Implement procedures to systematically assess smoking status and offer smoking cessation treatment to all HIV positive smokers.**

**Baseline/Goal:** Presently, Legacy does not offer a smoking cessation program. Our goal is to identify current smokers and offer them evidence-based treatment. **Data Source:** Primary data collection and program databases. **Rationale:** These efforts will help to solidify all aspects of the smoking cessation treatment program. Specifically, these efforts will solidify the integration of screening, enrollment, treatment, follow-up, data collection, and data transfer. **Milestone 4 Estimated Incentive Payment:** $245,896.60

**Milestone 5 [P-7]: Participate in population receiving innovative intervention consistent with evidence-based model.** Metric [I-5.1]: Estimated number of HIV-positive smokers receiving evidence-based cessation treatment Baseline/Goal: 0/500 Baseline - At the beginning of DY5, it is estimated that no HIV-positive smokers (other than those already enrolled in our program) will be receiving the cell phone-based treatment. Goal – By the end of DY5, we estimate that an additional 500 participants will be enrolled. **Date Source:** Documentation of target population reached. **Rationale:** HIV-positive smokers are a high risk yet underserved population. Thus, our efforts to disseminate our treatment approach to members of this population throughout the region fill a pressing public health need. **Milestone 12 Estimated Incentive Payment:** $147,592.33
**Project Title:** Implement innovative evidence-based strategies to reduce tobacco use - Evidence-Based Smoking Cessation Program for Underserved Persons Living with HIV/AIDS

<table>
<thead>
<tr>
<th>Performing Provider Name: The University of Texas MD Anderson Cancer Center</th>
<th>TPI - 112672402</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
</tr>
</tbody>
</table>

face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance.) Each participating provider should publicly commit to implementing these improvements. **Metric (P-7.1)** Participate in semiannual face-to-face meetings or seminars organized by the RHP. **Baseline/Goal:** 0/2 per year **Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Rationale:** These meetings will help to improve our efforts to efficiently reach and treat our target population of HIV positive smokers. **Metric (P-7.2)** Implement the “raise the floor” improvement initiatives established at the semiannual meeting.

- Other Outcome Improvement Target: (Quit Attempts)
- Other Outcome Improvement Target: (Staying Quit)
- Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity (Screening for Cigarette Smoking)
**Project Title:** Implement innovative evidence-based strategies to reduce tobacco use - Evidence-Based Smoking Cessation Program for Underserved Persons Living with HIV/AIDS

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

<table>
<thead>
<tr>
<th>Year</th>
<th>Outcome Measure(s)</th>
<th>Baseline/Goal</th>
<th>Data Source</th>
<th>Rationale</th>
<th>Milestone 5 Estimated Incentive Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>112672402.3.4 112672402.3.5 112672402.3.6</td>
<td>0/Goal of 100% of agreed upon improvement initiatives</td>
<td>Documentation of “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the “raise the floor” improvement initiative after the semiannual meeting.</td>
<td>Implantation of the improvement initiatives will help to improve our smoking cessation program.</td>
<td>$245,896.60</td>
</tr>
<tr>
<td>Year 4 Estimates</td>
<td>Other Outcome Improvement Target: (Quit Attempts) Other Outcome Improvement Target: (Staying Quit) Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity (Screening for Cigarette Smoking)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td>Year 2 Estimated Milestone Bundle Amount: $1,229,483.00 Year 3 Estimated Milestone Bundle Amount: $1,219,274.00 Year 4 Estimated Milestone Bundle Amount: $637,900 Year 5 Estimated Milestone Bundle Amount: $442,777</td>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,529,434.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Project Option 2.7.2 – Implement innovative evidence-based strategies to reduce tobacco use – Multimedia Tools and Community Engagement for Youth Early Tobacco Prevention and Cessation

Unique RHP Project ID: 112672402.2.3
Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402

Project Summary:
Provider: The University of Texas MD Anderson Cancer Center is a comprehensive cancer center ranked first in cancer care by *U.S. News & World Report* and dedicated to patient care, education, research and prevention. MD Anderson is comprised of several Texas Medical Center campus locations, two research campuses in Bastrop County, Texas, four regional care centers and a number of national and international divisions and affiliates. More than 108,000 people—almost one-third of them new patients—were seen in FY2011. MD Anderson provided $215 million in uncompensated charity care to Texans in FY2011.

Intervention(s): The centerpiece of the proposed project will be our evidence-based program ASPIRE (A Smoking Prevention Interactive Experience) which will be updated for contemporary youth while retaining its theoretical underpinnings and key modules. ASPIRE will be utilized to reach Medicaid eligible/indigent youth at various access points in RHP3 counties. Youth will be exposed to multilingual, culturally relevant anti-tobacco messages using electronic, digital and print media. Youth tobacco users and nonusers will join in the initiative and be exposed to five modules of tobacco prevention and cessation education. The clinical component of the project will involve recruiting and training RHP 3 providers who work with Medicaid patients to consistently screen adolescents and families for tobacco use, employing a carbon monoxide breath test for those ages 11 to 18, advising patients to adopt a nonsmoking lifestyle, referring patients proactively with links to the evidence-based ASPIRE program. The program’s smoking related goals and objectives will be achieved by offering the following activities: educating youth by engaging them in ASPIRE, training providers about addressing family tobacco use, using social media to help raise the public’s awareness of the addictiveness and dangers of tobacco. The source of advice delivered about cessation will be used from the 2008 Update for Treating Tobacco Use and Dependence. This approach recommends clinicians implement a series of counseling steps, referred to as the 5 As (ask, advise, assess, assist, and arrange). In the child health care setting, provision of the cessation advice would apply to relevant parents, children over 11 years of age, and adolescents in the clinical setting. The 5 As include asking, identifying, and documenting tobacco use at every visit. If identified, providers are to advise each smoker to quit using a “clear, strong, and personalized manner.” Another shorter technique will also be recommended for delivery. This technique can require a minute of time with patients in the providers’ office using the 3 As (asking, advising, and referring) to resources to meet the patients’ needs for tobacco prevention and cessation.

This project does not receive funding from nor does it advance any federal initiatives pertaining to CMS Innovation Center Grants, HITECH payments, HRSA grants, SAMHSA funding and CDC (immunization grants or CLASBI/ Hospital acquired infection) grants.
Need for the project:

- This project addresses Community Needs in RHP3: CN.11—High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease including: cancer, diabetes, obesity, cardiovascular disease, asthma, and AIDS/HIV; CN.12—High rates of tobacco use and excessive alcohol use; CN.20—Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs; CN.22—Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities; CN.23—Lack of patient navigation, patient and family education and information programs.

- In the state of Texas, over one third of students use tobacco products and at least two thirds of middle and high school students reported they were not exposed to anti-smoking messages.

- The crucial necessity of tobacco prevention among youth is dictated by the following major conclusions of the 2012 Report of the Surgeon General entitled, *Preventing Tobacco Use Among Youth and Young Adults*:
  1. Cigarette smoking by youth and young adults has immediate adverse health consequences, including addiction, and accelerates the development of chronic diseases across the full life course.
  2. Prevention efforts must focus on both adolescents and young adults because among adults who become daily smokers, nearly all first use of cigarettes occurs by 18 years of age (88%), with 99% of first use by 26 years of age.
  3. Advertising and promotional activities by tobacco companies have been shown to cause the onset and continuation of smoking among adolescents and young adults.
  4. After years of steady progress, declines in the use of tobacco by youth and young adults have slowed for cigarette smoking and stalled for smokeless tobacco use.
  5. Coordinated, multi-component interventions that combine mass media campaigns, price increases including those that result from tax increases, school-based policies and programs, and statewide or community-wide changes in smoke-free policies and norms are effective in reducing the initiation, prevalence, and intensity of smoking among youth and young adults.

- This project aims to reduce smoking initiation and facilitate smoking cessation among the vast majority of the aforementioned youth (i.e., ages 11 through 18 years). Importantly, it will address tobacco use among the most vulnerable low-income groups of youth who are Medicaid eligible/indigent being served by RHP3 clinics and schools, involving health professionals in sustainable activities that will lead to a dramatic reduction of tobacco use among the target population.

**Target Population:** Beginning in DY 3, 5% of Medicaid eligible/indigent participants will be recruited from Harris, Austin, and Colorado counties. In DY4 to DY 5, 5% of Medicaid eligible/indigent participants will be enrolled from Fort Bend, Chambers, and Matagorda counties. In DY 5, we will begin enrolling Medicaid eligible/indigent youth from Calhoun, Waller, and Wharton counties. The facilities targeted for provider training will be clinics, school-based student health clinics and schools. The schools will be utilized to increase reach and reinforce clinical activity among this population. All estimated figures are conservative.
Category 1 or 2 expected patient benefits:
- The baseline for DY2 is 4100 participants who have engaged in the evidence-based innovative ASPIRE program in Harris County.
- The DY3 goal is to enroll an estimated 5% of Medicaid-eligible/indigent participants from Harris, Austin, and Colorado counties, an estimated (n = 12,500 youth).
- The DY4 goal is to enroll 5% of Medicaid-eligible/indigent participants from Fort Bend, Chambers, and Matagorda counties, an estimated (n=2400).
- The DY5 goal is to enroll an estimated 5% of adolescents from Calhoun, Waller and Wharton counties (n=350).

Category 3 outcomes:
The three outcomes selected for this project will be three standard smoking-related outcomes from the literature as follows:

**IT-11.6:** Other Outcome Improvement Target (Reduction of Susceptibility to Tobacco) – Reduce susceptibility to tobacco usage among adolescents aged 11 to 18 years of age. A 3% reduction of participants susceptible to tobacco (n=100) will not initiate smoking at the time of follow-up.

**IT-11.6:** Other Outcome Improvement Target (Quit Attempts, participants refraining from using tobacco for at least 24 hours or longer, but does not result in quitting for an extended period of time). 30% of enrollees who smoke (n=600) will make a successful quit attempt.

**IT-11.6:** Other Outcome Improvement Target (Smoking Cessation/Staying Quit, being abstinent at follow-up). 10% of enrollees who smoke (n=200) will be abstinent at the time of follow-up.
Project Option 2.7.2 - Implement innovative evidence-based strategies to reduce tobacco use - Multimedia Tools and Community Engagement for Youth Early Tobacco Prevention and Cessation

Unique Project ID: 112672402.2.3
Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402

Project Description:
Tobacco is the number one preventable cause of death from cancer and other diseases. Nearly all tobacco use begins during the teenage years. Low-income, underserved youth are at highest risk for becoming tobacco users. For these reasons, we will target individuals aged 11 to 18 years and propose a tobacco prevention and cessation initiative utilizing multimedia resources as well as an extensive community network.

The program would prevent smoking initiation and facilitate cessation among those attending middle- and high-schools as well as for those youth attending office-based clinical encounters. Our evidence-based online tobacco program ASPIRE (A Smoking Prevention Interactive Experience) is free to the public and sustainable. It will serve as the primary resource for this project. ASPIRE will be utilized to reach Medicaid eligible/indigent youth at various access points in Regional Health Partnership (RHP) 3 counties. Youth will be exposed to multilingual, culturally relevant anti-tobacco messages using electronic, digital and print media. By the end of year 5 we anticipate enrolling more than 15,250 adolescents in RHP3 counties into the ASPIRE program. According to the US Bureau of the US Census, the total estimated number of youth aged 11 to 18 years in RHP3 is approximately 1.3 million. We estimated that at least 25% of these adolescents are Medicaid eligible/indigent (about 305,500). Then we estimated that 5% of these low income adolescents (15,250) will enroll in this project (connecting to ASPIRE and/or introduced by providers during clinical encounters). According to results from the 2002 to 2008 National Surveys on Drug Use and Health, approximately 13% are current smokers (varies by age, gender, ethnicity and other factors). The estimated number of participants for this project is based on the aforementioned data source.

This project does not receive funding from nor does it advance any federal initiatives pertaining to CMS Innovation Center Grants, HITECH payments, HRSA grants, SAMHSA funding and CDC (immunization grants or CLASBI/ Hospital acquired infection) grants.

Goal(s) and Relationship to Regional Goal(s):
This project will influence knowledge, attitudes, and perceptions of young people about tobacco products. If participants are smokers they will be encouraged to make quit attempts and sustained cessation. Receipt of ASPIRE’s health education, in turn will lead to reduced consumption of tobacco products and incidence of tobacco-related disease among participants, thereby increasing the future health and wellbeing of Region 3 adolescents.

This initiative will employ a range of activities and services to include: provider/educator training, youth engagement through school-based events, social networking/online advertising, and other group activities; community outreach with incentives/contests around national anti-
tobacco events, youth education and counseling (including expectant teen mothers), and parental/family and community involvement. Furthermore, our concept will require the involvement of clinics (e.g., prenatal, family planning, STD, WIC) and middle- and high-schools. Examples of providers include: health care providers, administrative and educational personnel in schools. The source of clinical advice delivered about cessation will be referenced from the 2008 Update for Treating Tobacco Use and Dependence. This approach recommends clinicians implement a series of counseling steps, referred to as the 5 As (ask, advise, assess, assist, and arrange). Provision of the cessation advice would apply to relevant parents, children over 11 years of age, and adolescents in the clinical setting. The 5 As include asking, identifying, and documenting tobacco use at every visit. If identified, providers are to advise each smoker to quit using a “clear, strong, and personalized manner.” Another shorter delivery technique will also be recommended. This technique can require a minute of time with patients in the providers’ office using the 3 As (asking, advising, and referring) to resources to meet the patients’ needs for tobacco prevention and cessation.

This project meets the following regional goals:

- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

Challenges:
A main challenge will be the recruitment and retention of youth (i.e., maintaining their interest, motivation and commitment to the program). Secondarily, technology can pose its own challenges (e.g. glitches, bandwidth, software compatibility, etc.). Another challenge is related to the consistency of ASPIRE implementation among our partners. These obstacles can be successfully addressed by the implementation team. They have considerable experience in working with young, disadvantaged populations and intervention delivery. The director of this initiative, Dr. Alex Prokhorov has 30 years of experience in preventing youth tobacco use among underserved populations. We plan to also leverage the expertise of other collaborators. Dr. Vidrine possesses expertise in technology-based tobacco cessation intervention program creation and implementation among low-income populations. Dr. Karen Calabro works in anti-tobacco health education and research in young populations. We will collaborate with Salma Marani (biostatistician for various tobacco and youth studies), and Lauren McCoy (health marketing/communications professional). Another strategic advantage for this initiative is the provision of resources that can compensate both individual participants and member partners (i.e., furnishing computer resources to facilitate youth viewing of ASPIRE within partner facilities).

5-Year Expected Outcome for Provider and Patients:
1. Enroll 5% of Medicaid-eligible/indigent youth from an estimated (n = 15,250 total youth) across the RHP3 counties. The approach selected for enrolling participants is planned to be operationalized by recruiting in blocks of three counties annually.
o DY3: We will enroll an estimated 12,500 youth from Harris, Austin, and Colorado counties.

o DY4: We will expand the operation to reach the Fort Bend, Chambers, and Matagorda counties enrolling 2,400 youth.

o DY5: We will expand the operation extending into Calhoun, Waller, and Wharton where we expect to enroll an estimated 350 youth.

2. Reduce susceptibility to tobacco use by 3% (n = 100) among 3150 susceptible to tobacco across the RHP3 counties. Annual estimates for reducing susceptibility:
   o DY3: 70 youth
   o DY4: 15 youth
   o DY5: 15 youth

3. Increase quit attempts among program participants for 24 hours within the estimated group of 1,980 smokers by 30% (n = 600). Numbers of quit attempts for each year are:
   o DY3: 420 smokers
   o DY4: 90 smokers
   o DY5: 90 smokers

4. Increase sustained cessation among the estimated 1980 smokers in RHP3 by 10% (n = 200). Estimates of numbers of smokers not smoking at follow-up (sustained quitters) for each year are:
   o DY3: 100 smokers
   o DY4: 50 smokers
   o DY5: 50 smokers

5. Train and equip providers within clinics including dental clinics serving Medicaid-eligible/indigent youth in RHP3 and schools to offer anti-tobacco counseling and cessation resources. Counties covered for each year are:
   o DY3: Harris, Austin, and Colorado counties
   o DY4: adding Fort Bend, Chambers, and Matagorda counties.
   o DY5: adding Calhoun, Waller, and Wharton

**Starting Point/Baseline:**
The ASPIRE initiative is an existing program with widespread reach. Within the Houston area, 4,100 adolescents are engaged in ASPIRE or have been exposed to ASPIRE (year-to-date from 2008 to August 2012).

**Rationale:**
Project Option 2.7.2 was selected because ASPIRE is an evidence-based program proven to reduce the uptake of tobacco use among underserved teenagers at highest risk for smoking initiation.

In the state of Texas, over one third of students use tobacco products and at least two thirds of middle and high school students reported they were not exposed to anti-smoking
messages. Concurrently, youth are known to be heavy users of technology. For these reasons we will specifically focus on reaching underserved youth within RHP3 counties using a technology-based program that is evidence-based for high-risk adolescents. ASPIRE was tested among inner-city youth in urban Houston high schools. ASPIRE proved to be effective in preventing smoking initiation. The program is used by adolescents in counties within Texas, is easily accessible via the Internet and is available at no cost to users. Additional funding will allow us to enhance the sustainability of ASPIRE and to offer better incentives for broader program participation. Additionally, the ASPIRE program can be easily implemented as it is self-directed for the students.

**Project Components:**
The activities of this initiative include efforts to train providers and community partners to consistently refer adolescents to tobacco prevention and tobacco cessation resources, which can lead to widespread delivery of tobacco prevention services in the RHP3 counties [P-6; IT-11.6]. The facilities targeted for provider training will be school-based student health clinics, community clinics and schools that serve Medicaid eligible/indigent youths. The source of advice about cessation delivery to be used will be from the 2008 Update for Treating Tobacco Use and Dependence. This approach recommends clinicians implement a series of counseling steps, referred to as the 5 As (ask, advise, assess, assist, and arrange). In the health care setting, provision of the cessation advice would apply to relevant parents, children over 11 years of age, and adolescents in the clinical setting. The 5 As include asking, identifying, and documenting tobacco use at every visit. If identified, providers are to advise each smoker to quit using a “clear, strong, and personalized manner.” Another shorter technique will also be recommended for delivery. This technique can require a minute of time with patients in the providers’ office using the 3 As (asking, advising, and referring) to resources to meet the patients’ needs for tobacco prevention and cessation.

**Milestones & Metrics:**
The following milestones and metrics were selected for the ASPIRE youth tobacco use prevention and cessation project based on the needs of the target population:

- Process Milestones and Metrics: P-1 (P-1.1); P-2(P-2.1), P-7 (P-7.1)
- Improvement Milestone and Metric: I-X (I-X.1)

**Unique community need identification number the project addresses:** The project addresses the following unique community needs identified in the Region 3 community needs assessment:
- CN.11- High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including
  - Cancer
  - Diabetes
  - Obesity
  - Cardiovascular disease
  - Asthma
  - AIDS/HIV
• CN.12 - High rates of tobacco use and excessive alcohol use
• CN.20 - Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
• CN.22 - Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities
• CN.23 - Lack of patient navigation, patient and family education and information programs.

How the project represents a new initiative for the Performing Provider or significantly enhances an existing deliver system reform initiative:
Currently, there is no evidence-based tobacco prevention and cessation program that is available to teens in RHP3 counties at no cost to participants. This initiative will not only introduce this culturally-tailored resource to Medicaid-eligible/indigent adolescents, but also provide access to tobacco education in support of positive health outcomes. From 2008 to 2012 we had success in reaching 4100 diverse, low income participants in Harris County. During DY3 to DY5, we also plan to have bi-annual meetings with other RHP providers to contribute to the sharing of ideas and identifying best practices for the region.

Related Category 3 Outcome Measure(s):
• IT-11.6: Other Outcome Improvement Target (Reduction of Susceptibility to Smoking) – Reduce susceptibility to tobacco usage among adolescents aged 11 to 18 years of age among 3% of enrollees. In absolute numbers this will be (n = 100 of 3,150 youth) susceptible to tobacco use will not initiate smoking at the time of follow-up
• IT-11.6: Other Outcome Improvement Target (Quit Attempts) – an estimated 30% of enrollees (n = 600 of 1,980 smokers) will make at least one quit attempt.
• IT-11.6: Other Outcome Improvement Target (Smoking Cessation/Staying Quit) – an estimated 10% of enrollees who smoke (n = 200 of 1,980 smokers) will be abstinent at the time of follow-up.

Reasons/rationale for selecting the outcome measure(s):
Clinicians may regard treatment for tobacco as mostly pertaining to offering interventions to established adult smokers. A focus on promoting quit attempts and sustained tobacco abstinence similarly applies to youth. In fact, nearly 20% of youth that have never smoked are susceptible to smoking. Thus, youth tobacco prevention and cessation efforts require different approaches as compared to adults (e.g. quitlines, medications, etc.). It is necessary to employ a unique and evidenced-based method such as ASPIRE to curb tobacco use among youth.

As part of this project’s preparation and to establish the foundation necessary for achieving Category 3 outcomes, we will focus on: infrastructure development, delivery service improvement/program development, provider training, and staff hiring and training. By enhancing existing resources and activities, the proposed project will permit us to dramatically increase the reach of this evidence-based program throughout Medicaid-eligible/indigent adolescents in the nine counties of RHP3.

During the process of becoming an established smoker, a young person transitions through several stages –from not susceptible to susceptible, progressing to smoking initiation, and current
smoking. This ASPIRE program is compatible with the aforementioned Category 3 outcome measure, because ASPIRE provides access to prevention and cessation services virtually nonexistent in these communities. More specifically, the ASPIRE program was tested with an 18-month randomized controlled study among 1,160 ethnically diverse students from 16 inner-city high schools in Houston. About 6% of control group participants initiated smoking whereas < 2% of the intervention group initiated smoking (p < .05). (1) According to the 2010 U.S. Bureau of the Census, there are approximately 1.4 million adolescents residing in RHP3 counties. Within this figure, we conservatively estimate that nearly 305,500 youth within this group (i.e., 25%) are eligible for Medicaid/indigent. Our efforts will result in reduced susceptibility, increased quit attempts and increased cessation among disadvantaged RHP3 adolescents. The cumulative effect of all these activities will lead to significant reduction of tobacco use among high risk youth.

**Relationship to Other Projects:**
By delivering a tobacco use prevention and cessation program to youth, this project, like our other projects, supports one of the eight goals of the Comprehensive Cancer Control Program at MD Anderson Cancer Center.

**Relationship to Other Performing Providers’ Projects in the RHP:**
Healthcare treatment cannot focus to only the acute or chronic encounter and properly treat the patient. It is critical that our region focuses to patient education and community education to ensure a proactive and responsive approach to healthcare needs. The education models represented in the Region 3 RHP plan can be identified in the Initiative Grid (addendum) and all focus to outcome measures such as appropriate utilization, patient satisfaction scores, and standalone chronic condition scores such as diabetes and asthma.

**Plan for Learning Collaborative:** We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for RHP 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

**Project Valuation:** We have based our project valuation on California’s 1115 Medicaid Waiver model. As such, we have valued our projects at 2.5 times that of the estimated costs. Basing our valuations on California’s calculations we know we are well within the potential range of future cost savings when looking at the following from Prevention Institute and Trust for America’s Health Issue Report entitled *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities (July 2008):*

- Prevention saves money – an investment of $10 per person per year in programs to increase physical activity, improve nutrition, and prevent tobacco use could save the country more than $16 billion in annual health care costs within five years.
- Prevention can reduce end-of-life costs by increasing health during the lifespan, what researchers call the *compression of morbidity*.
- There is a substantial return-on-investment in prevention – For every $1 invested in community-based prevention, the return amounts to $5.60.
**Project Title:** Implement innovative evidence-based strategies to reduce tobacco use - Multimedia Tools and Community Engagement for Youth Early Tobacco Prevention and Cessation

**The University of Texas MD Anderson Cancer Center**

<table>
<thead>
<tr>
<th>Unique Identifier: 112672402.2.3</th>
<th>RHP PP Reference Number: 2.7.2</th>
<th>Project Components: 2.7.2</th>
<th>Related Category 3 Outcome Measure(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>112672402.3.7</td>
<td>IT-11.6</td>
<td>IT-11.6</td>
<td>IT-11.6</td>
</tr>
<tr>
<td>112672402.3.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>112672402.3.9</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2** (10/1/2012 – 9/30/2013)

**Milestone 1 [P-1]:** Establish project infrastructure development (staff, resources, community partners) for the implementation of evidence-based ASPIRE program in Region 3 counties.

**Metric 1 [P-1.1]:** Hire and train personnel to support and manage the project.

**Baseline/Goals:** Our goal is to hire and train at least 4 new personnel to support and manage the project.

**Data Source:** Records of planning, job postings, and documents from human resources databases

**Rationale/evidence:** It is imperative to identify and hire qualified personnel to deliver this smoking prevention and cessation resource that lays the groundwork for widespread adoption of innovative care leading to better health and better care at reduced costs.

**Metric 2 [P-1.2]:** Establish relationships with community

| Year 3 | Year 4 | Year 5 |

**Milestone 4 [P-2]:** Implement evidence-based innovative ASPIRE program among Medicaid-eligible adolescents from Harris, Austin, and Colorado counties through schools and clinics.

**Metric 1 [P-2.1]:** Medicaid-eligible/indigent adolescents enrolled into ASPIRE program.

**Baseline/Goal:** Baseline of nearly 4,100 enrolled ASPIRE participants in the Houston area. Goal: expand ASPIRE reach to Medicaid-eligible/indigent youth from 9 sites in Harris, Austin, and Colorado counties.

**Data Source:** Records of program planning, correspondence, and ASPIRE data system

**Rationale/evidence:** It is imperative to identify and hire qualified personnel to deliver this smoking prevention and cessation resource that lays the groundwork for widespread adoption of innovative care leading to better health and better care at reduced costs.

**Metric 2 [P-2.2]:** Establish relationships with community

**Milestone 6 [P-2]:** Implement evidence-based innovative ASPIRE program among adolescents from Fort Bend, Chambers and Matagorda counties through schools and clinics.

**Metric 1 [P-2.1]:** Medicaid-eligible/indigent adolescents enrolled into ASPIRE program.

**Baseline/Goal:** Anticipate enrolling an additional 2,400 participants over DY3 baseline.

**Data Source:** Documentation of efforts, ASPIRE data system

**Milestone 8: Estimated Incentive Payment:** $2,364,075.00

**Milestone 7 [P-7]:** Participate in bi-annual meetings with other RHP providers and identify areas for improvement

**Metric [P-7.1]:** Attendance in at least 2 semi-annual face-to-face meetings organized by the RHP

**Baseline/Goal:** Require that a
<table>
<thead>
<tr>
<th>Year 2  &lt;br&gt; (10/1/2012 – 9/30/2013)</th>
<th>Year 3  &lt;br&gt; (10/1/2013 – 9/30/2014)</th>
<th>Year 4  &lt;br&gt; (10/1/2014 – 9/30/2015)</th>
<th>Year 5  &lt;br&gt; (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>partners in clinics and schools</strong></td>
<td><strong>delivers better health, better care at reduced costs</strong></td>
<td><strong>baseline/goal: require that a representative of the participating schools and clinics attend the meeting</strong></td>
<td><strong>baseline/goal: requirement that a representative of the participating schools and clinics attend the meeting</strong></td>
</tr>
<tr>
<td><strong>baseline/goals:</strong> The goal is to identify community partners at educational/clinical facilities receptive to joining the project</td>
<td><strong>milestone 4: estimated incentive payment:</strong> $2,264,075.00 $2,364,075.00</td>
<td><strong>data source:</strong> documentation of attendance in at least 2 semi-annual face-to-face meetings organized by the RHP</td>
<td><strong>data source:</strong> documentation of attendance in at least 2 semi-annual face-to-face meetings organized by the RHP</td>
</tr>
<tr>
<td><strong>data source:</strong> Correspondence with community partners, documentation of meetings, securing of contracts</td>
<td><strong>milestone 5 [P-7]: participate in biannual meetings with other RHP providers and identify areas for improvement</strong></td>
<td><strong>rationale/evidence:</strong> Continuous learning is promoted when providers share and exchange experiences when implementing the project. This is necessary to meet the objective of the “raise the floor” improvement across all providers after the semiannual meeting.</td>
<td><strong>rationale/evidence:</strong> Continuous learning is promoted when providers share and exchange experiences when implementing the project. This is necessary to meet the objective of the “raise the floor” improvement across all providers after the semiannual meeting.</td>
</tr>
<tr>
<td><strong>milestone 1: estimated incentive payment:</strong> $1,575,000.00</td>
<td><strong>metric [P-7.1]: Participation of providers in at least 2 semi-annual face-to-face meetings organized by the RHP</strong></td>
<td><strong>baseline/goal:</strong> 0:2 require that a representative of the participating schools and clinics attend the meeting</td>
<td><strong>baseline/goal:</strong> requirement that a representative of the participating schools and clinics attend the meeting</td>
</tr>
<tr>
<td><strong>milestone 2 [P-1]: Complete delivery service improvement for the evidence-based ASPIRE program and other corresponding products for RHP 3 counties.</strong></td>
<td><strong>data source:</strong> documentation of attendance in at least 2 semi-annual face-to-face meetings organized by the RHP</td>
<td><strong>rationale/evidence:</strong> Continuous learning is promoted when providers share and exchange experiences when implementing the project. This is necessary to meet the objective of the “raise the floor” improvement across all providers after the semiannual meeting.</td>
<td><strong>rationale/evidence:</strong> Continuous learning is promoted when providers share and exchange experiences when implementing the project. This is necessary to meet the objective of the “raise the floor” improvement across all providers after the semiannual meeting.</td>
</tr>
<tr>
<td><strong>metric1[P-1.1]: Enhance program</strong></td>
<td><strong>milestone 6: estimated incentive payment:</strong> $2,264,075.00 $2,364,075.00</td>
<td><strong>milestone 7: estimated incentive payment:</strong> $2,264,075.00 $2,364,075.00</td>
<td><strong>milestone 10 [I-X]: Identify the number of age-eligible adolescent patients in defined clinics that deliver smoking cessation consistent with evidence-based model.</strong></td>
</tr>
<tr>
<td><strong>related category 3 outcome measure(s):</strong> 112672402.3.7 112672402.3.8 112672402.3.9</td>
<td><strong>Rationale/evidence:</strong> Continuous learning is promoted when providers share and exchange experiences when implementing the project. This is necessary to meet the objective of the “raise the floor” improvement across all providers after the semiannual meeting.</td>
<td><strong>metric [I-X.1]: Assess outcomes, both short-term and intermediate,</strong></td>
<td><strong>metric [I-X.1]: Assess outcomes, both short-term and intermediate,</strong></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td><strong>Project Title:</strong> Implement innovative evidence-based strategies to reduce tobacco use - Multimedia Tools and Community Engagement for Youth Early Tobacco Prevention and Cessation</td>
<td>The University of Texas MD Anderson Cancer Center</td>
<td>112672402</td>
<td>112672402.3.7</td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td>content of ASPIRE program and CME training (i.e. ASPIRE app, site and CME training materials)</td>
<td>Baseline/goals: The existing ASPIRE program website and app as well as the existing CME materials will be updated. The goal would be to update these materials with more modern-day teen friendly content.</td>
<td>Data source: Correspondence with vendors, documentation of iterations of refining</td>
</tr>
</tbody>
</table>

**Baseline/Goal:** Baseline of nearly 4,100 enrolled ASPIRE participants in the Houston area. Goal: expand ASPIRE reach to Medicaid-eligible/indigent youth within 4 clinics in Region 3 counties.

**Data Source:** Records of correspondence and ASPIRE data system

**Rationale/evidence:** It is prudent to perform basic evaluations to learn whether systems change and delivery improvements occur. In this way quality improvement can be fostered.
## Project Title
Implement innovative evidence-based strategies to reduce tobacco use - Multimedia Tools and Community Engagement for Youth Early Tobacco Prevention and Cessation

### The University of Texas MD Anderson Cancer Center

#### Related Category 3 Outcome Measure(s):
- 112672402.3.7
- 112672402.3.8
- 112672402.3.9

#### Year 2
(10/1/2012 – 9/30/2013)

**Data source:** Correspondence with event venues and school administration

**Rationale/evidence:** Kickoff events will be helpful in generating awareness and interest in the upcoming tobacco prevention and cessation activities in the Region 3 counties. Such events have proven to be effective among teens in other regions.

**Metric 3[P-1.3]:** Enroll and train providers working in clinics and schools that serve age-eligible, Medicaid-eligible/indigent adolescents.

**Baseline/goal:** Recruit clinics and schedule training among 2% of schools and clinics in the region serving age-eligible, Medicaid-eligible/indigent adolescents.

**Data source:** CME training materials and sessions that will be offered

#### Year 3
(10/1/2013 – 9/30/2014)

- IT-11.6
- IT-11.6
- IT-11.6

#### Year 4
(10/1/2014 – 9/30/2015)

- Other Outcome Improvement Target (Reduction of Susceptibility to Smoking)
- Other Outcome Improvement Target (Quit Attempts)
- Other Outcome Improvement Target (Smoking Cessation/Staying Quit)

#### Year 5
(10/1/2015 – 9/30/2016)

- 112672402
### RHP PP Reference Number: 2.7.2

**Project Components:** 2.7.2

**Project Title:** Implement innovative evidence-based strategies to reduce tobacco use - Multimedia Tools and Community Engagement for Youth Early Tobacco Prevention and Cessation

**The University of Texas MD Anderson Cancer Center**

**Related Category 3 Outcome Measure(s):**
- 112672402.3.7
- 112672402.3.8
- 112672402.3.9
- IT-11.6
- IT-11.6
- IT-11.6
- Other Outcome Improvement Target (Reduction of Susceptibility to Smoking)
- Other Outcome Improvement Target (Quit Attempts)
- Other Outcome Improvement Target (Smoking Cessation/Staying Quit)

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>to providers; correspondence with community partners, documentation of meetings</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Rationale/evidence:**
Providers in the health care setting will be trained to efficiently deliver counseling that addresses tobacco use prevention and cessation methods. They will be able to consistently deliver tobacco prevention, cessation, and refer patients to the ASPIRE program

**Metric 4[P-1.4]:** Create marketing materials for launch of program

**Baseline/goals:** The goal is to create and order print and online materials as well as giveaways for the students.

**Data source:** Vendor contracts, agency contact, final print and online materials

**Rationale/evidence:** These materials will be used to increase awareness about the program and its program
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project Title:</strong> Implement innovative evidence-based strategies to reduce tobacco use - Multimedia Tools and Community Engagement for Youth Early Tobacco Prevention and Cessation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The University of Texas MD Anderson Cancer Center</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RHP PP Reference Number:</strong> 2.7.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 3 Outcome Measure(s):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 112672402.3.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 112672402.3.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 112672402.3.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• IT-11.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• IT-11.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• IT-11.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other Outcome Improvement Target (Reduction of Susceptibility to Smoking)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other Outcome Improvement Target (Quit Attempts)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other Outcome Improvement Target (Smoking Cessation/Staying Quit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 2 Estimated Incentive Payment:</strong> $1,575,000.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3 [P-7]:</strong> Participate in bi-annual meetings with other RHP providers and identify areas for improvement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric [P-7.1]:</strong> Participation of providers in at least 2 semi-annual face-to-face meetings organized by the RHP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal:</strong> Require that a representative of the participating schools and clinics attend the meetings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data source:</strong> Documentation of attendance in at least 2 semi-annual face-to-face meetings organized by the RHP</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Rationale/evidence:** Continuous learning is promoted when providers...

activity. The giveaways will also serve as an incentive for student participation.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

### Related Category 3 Outcome Measure(s):
- 112672402.3.7
- 112672402.3.8
- 112672402.3.9
- IT-11.6
- IT-11.6
- IT-11.6
- Other Outcome Improvement Target (Reduction of Susceptibility to Smoking)
- Other Outcome Improvement Target (Quit Attempts)
- Other Outcome Improvement Target (Smoking Cessation/Staying Quit)

### Share and Exchange Experiences
- Necessary to meet the objective of the “raise the floor” improvement across all providers after the semiannual meeting.

### Milestone 3 Estimated Incentive Payment:
- $1,575,000.00

### Year 2 Estimated Milestone Bundle Amount:
- $4,725,000.00

### Year 3 Estimated Milestone Bundle Amount:
- $4,728,150.00

### Year 4 Estimated Milestone Bundle Amount:
- $4,728,150.00

### Year 5 Estimated Milestone Bundle Amount:
- $4,728,150.00

### TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $18,909,450.00
Project Option 2.7.1 – Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.): Expand Project VALET
Unique RHP Project ID: 112672402.2.4
Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402

Project Summary:
Provider: The University of Texas MD Anderson Cancer Center is a comprehensive cancer center ranked first in cancer care by U.S. News & World Report and dedicated to patient care, education, research and prevention. MD Anderson is comprised of several Texas Medical Center campus locations, two research campuses in Bastrop County, Texas, four regional care centers and a number of national and international divisions and affiliates. More than 108,000 people—almost one-third of them new patients—were seen in FY2011. MD Anderson provided $215 million in uncompensated charity care to Texans in FY2011.

Intervention(s): This project will expand Project VALET (Providing Valuable Area Life-Saving Exams in Town), a breast cancer screening mammography service for uninsured, low-income or Medicaid eligible women, ages 40 to 69 in Houston, to the RHP3’s coverage area.

Need for the project: A) This project addresses the following unique community needs in the RHP3: CN.2-Inadequate access to specialty care; CN.11-High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with cancer; CN.20-Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs; CN.21-Inadequate transportation options for individuals in rural areas and for indigent/low-income populations; CN.22-Insufficient access to services that are specifically designed to address racial, ethnic, and culturally health disparities. B) This program has consistently increased the numbers of uninsured, low-income or Medicaid eligible women – especially racial/ethnic minorities, such as Hispanic and African American – getting screened for breast cancer. Since its inception, Project VALET has demonstrated that despite Houston’s vast medical services, the percentage of women in need of breast cancer screening is still high (36%). Barriers to care, such as lack of transportation, partially explain low screening rates in this population. Currently, the number of screening appointments needed exceeds the available screening capacity.

Target Population: Women within the RHP3 counties eligible to participate in Project VALET are ages 40 to 69, asymptomatic, and uninsured, low-income or Medicaid eligible women. Women must also receive a clinical breast exam at one of the participating clinics before scheduling a screening mammogram with MD Anderson Mobile Mammography Appointment Line.

Category 1 or 2 expected patient benefits: The DY4 goal is to increase the number of breast cancer screenings provided by 166% over DY3 (1,200 screening mammogram services will be provided). The DY5 goal is to increase the number of breast cancer screenings provided by 25% over DY4 by extending project in two additional RHP area clinics (1,500 screening mammogram services will be provided).

Title of Outcome Measure (Improvement Target): IT-12.6: Other Outcome Improvement Target: Women in need of diagnostic test(s). IT-12.6: Other Outcome Improvement Target: Women returning for an annual mammogram per recommended screening guidelines. IT-12.1: Breast Cancer Screening (HEDIS 2012) Number of women, ages 40 to 69, who have received an annual mammogram during the reporting period and number of women ages 40 to 69 in service area who meet Project VALET’s eligibility criteria.
Project Option 2.7.1  Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.) – Expansion of Project VALET of Screening Mammograms

**Unique Project ID:** 112672402.2.4  
**Performing Provider Name/TPI:** The University of Texas MD Anderson Cancer Center / 112672402  
**Project Description:**

The University of Texas MD Anderson Cancer Center (MD Anderson) will expand Project VALET (Providing Valuable Area Life-Saving Exams in Town), a breast cancer screening mammography service for uninsured women, ages 40 and older in Houston, to the RHP3’s coverage area. Current partners include The Rose, a non-profit breast organization, and the Houston Department of Human and Health Services (HDHHS)

For the past four years, Project VALET has relied on the MD Anderson Diagnostic Imaging’s availability to provide screening dates with their sole digital mobile mammography van. Since the majority of their screening dates are reserved for long-standing corporate clients and clinics, the acquisition of a new mobile mammography van would enable Project VALET to increase its screening capacity, thus reaching uninsured, low income or Medicaid eligible women and expanding its geographic coverage to include neighboring clinics within the RHP3 area.

Project VALET’s overall goals align with the regional goals since they will leverage existing programs which offer well-woman exams and enhance them by providing free screening mammograms to underserved populations that might not otherwise have access to this specialty care or the ability to pay for it. Doing so will increase the number of uninsured, low income or Medicaid eligible women in the RHP3 who receive a clinical breast exam and screening mammogram, especially those who have not been compliant with the recommended American Cancer Society (ACS) screening guidelines for the early detection of breast cancer. It will also increase the number of women who will return, through Project VALET, for their annual screening mammogram. (The ACS guidelines used for breast cancer are an annual clinical breast exam for asymptomatic women age 40 and older as a part of a periodic health examination as well as annual mammography) (1). This implements best-practices and maximizes the use of technology. This will reinforce patients to adopt preventive health care measures and in the process, positively impact breast cancer outcomes.

This project does not receive funding from nor does it advance any federal initiatives pertaining to CMS Innovation Center Grants, HITECH payments, HRSA grants, SAMHSA funding and CDC (immunization grants or CLASBI/ Hospital acquired infection) grants.

**Target Population and Eligibility:** To be eligible to participate in Project VALET, a woman must be 40 years of age or older, asymptomatic and uninsured, low income or Medicaid eligible. (Citizenship or legal residency status will not be requested.) After receiving a clinical breast exam at one of the participating clinics, women meeting the eligibility criteria will be given the phone number to the MD Anderson Mobile Mammography Appointment Line and information on what to expect on the day of the screening event. (The information will be available in English and Spanish as well as any other language, should a population require this.) It is the woman’s responsibility to schedule her screening mammogram. MD Anderson Mobile Mammography Appointment Line staff members will make a reminder call to the patient 24-
hours in advance of her appointment. On the screening day, the patient will complete her registration forms, receive an educational packet with breast health information and the instructions for the referral process for women in need of diagnostic tests with program partners. She will also self-address a postcard to be sent to her residence the following year, as a reminder to return for her annual screening mammogram. (Postcards will be sent one month prior to the recommended screening date.). Two to three weeks after the screening event, both the patient and her referring clinic will receive a copy of the screening result. If the result is negative, the woman is encouraged to return for an annual screening mammogram. If positive, the community health worker (CHW) will navigate the woman to a partner facility for screening/diagnostic follow up.

Goal(s) and Relationship to Regional Goal(s):
The goal of this project is to utilize an evidence-based approach in RHP3 clinics to increase breast cancer screening to women, ages 40-69, who qualify for a free, breast screening mammogram. Culturally appropriate material will be distributed to all women who go in for a well-woman exam.

To ensure the success of this project, the program staff manager will train clinic staff and CHWs on the process of how to obtain a screening mammogram; ensure that proper data and documentation is being collected; attend screening events to help register patients and answer any questions that might arise.

Project Goals:
- Assess the number of women who have previously received a screening mammogram
- Increase the number of uninsured, low income and Medicaid eligible women who have received a screening mammogram in RHP3 and who return for their annual screening mammogram
- Establish base-line mammograms for traditionally non-compliant populations
- Increase the frequency and geographical range of screening mammogram events in the RHP3

This project meets the following Region 3 goals:
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

The Project VALET Expansion program aims to reduce the incidence and mortality of breast cancer by offering free screening mammograms to women who qualify, in a participating neighborhood clinic. This project will be implemented in three counties within the RHP3 geographic area. Clinics targeted are: Houston Department of Health and Human Services, Federally Qualified Health Centers (FQHCs), and other clinics that provide well-woman exams.

Challenges:
Internal challenges: First and foremost, all program planning and implementation hinges on purchasing a new, digital mobile mammography van, without which, it is impossible to add more screening dates and/or clinics. This is imperative since we have reached the maximum amount of days available with the current van. The additional van will allow for both increased...
capacity and also provide back-up coverage for our current van, which is experiencing some mechanical issues due to age. (Historically, Project VALET cancels an average of four to five screenings per year due to this problem.) This has limited the range of services provided.

**External challenges:** A challenge is recruiting women who are unaccustomed to seeking preventive care because of financial barriers or the fear of getting screened without resources for diagnostic testing and/or treatment, should they need them. The CHWs will create educational folders with breast cancer information and help navigate the patient in the referral process for women in need of diagnostic tests with program partners. The CHWS and the program staff will be available for additional questions or issues that might arise.

**Environmental challenges:** Inclement weather (e.g., heavy rainfall) typically increases the no-show rate because some of the patients take public transportation or walk to the screening events.

**Five-year Expected Outcome for Provider and Patients:**

- Increase the number of uninsured, low income and Medicaid eligible women adhering to ACS’ breast cancer screening guidelines, including those who return for ACS’ recommended annual screening mammogram
- Establish base-line mammograms for traditionally non-compliant populations
- Increase the frequency of screening mammogram events in RHP3
- From DY3 – DY5, the program will deliver an estimated total of 3,500 screening mammograms. The breakdown is as follows:
  - **DY3:**
    - 800 screening mammogram services will be provided
    - 40 women served with diagnostic test(s)
  - **DY4:**
    - 1,040 screening mammogram services will be provided
    - 160 women returned for an annual screening mammogram
    - 60 women served with diagnostic test(s)
  - **DY5:**
    - 1,200 screening mammogram services will be provided
    - 300 women returned for an annual screening mammogram
    - 75 women served with diagnostic test(s)

**Starting Point/Baseline:**
From June 2008 to December 2012, Project VALET has provided 1,263 screening mammograms from approximately 1,500 encounters with potential participants. Ninety percent of the providers affiliated with this program have received training on how to implement Project VALET. Since this is an expansion project, the baseline will be determined after an initial period of operation.

**Rationale:**
Project VALET was selected because it has been successfully implemented on a smaller scale in the City of Houston. Furthermore, this program has consistently increased the numbers of uninsured and low-income women – especially racial/ethnic minorities, such as Hispanic and African American – getting screened for breast cancer. Since its inception, Project VALET has demonstrated that despite Houston’s vast medical services, the percentage of women in need of
breast cancer screening is still high (36%) (2). Barriers to care such as lack of transportation partially explain low screening rates in this population (3). Currently, the number of screening appointments needed exceeds the available screening capacity.

More than 2,800 women are expected to die this year in Texas as a result of breast cancer (4) and many of the women who die will present with late-stage disease because they did not participate in breast cancer screenings (5). Breast cancer death rates are highest for Black women (6). Indigent/low-income women and Hispanic women (7) are less likely to get annual breast screenings. Lack of insurance has been associated with significantly worse outcomes for several other cancer sites, specifically breast cancer (8). Moreover, malignant neoplasms exceed heart disease as a cause of death for Hispanics and the burden of cancer is more prominent in counties with larger numbers of Hispanics such as those in RHP3 (9). The insurance barrier impacts indigent/low income women disproportionately. This population has a higher rate of non-compliance with recommended mammography screening. Overall, lower incomes, lack of insurance and Hispanic ethnicity have been identified as factors associated with decreased participation in routine cancer screening.

Because this is a mobile mammography program that offers screening at low or no cost to participants, the barriers based on cost of services and lack of transportation to screening locations are eliminated. Furthermore, the project will addresses health care disparities due to language and cultural barriers because services and educational materials will be provided in Spanish, as well as any other language, should a population require this, using a culturally-tailored program for those in need of this approach.

Project Components:
Through Project VALET’s Expansion Program (the program will deliver an estimated total of 3,500 screening mammograms from DY3 – DY5), we propose to meet all project components and believe that the selected milestones and metrics relate to project components. There are no required core project components for Project Option 2.7.1.

Milestones & Metrics:
The following milestones and metrics have been chosen for the Expansion of Project VALET based on the project development and the needs of the target population:
- Process Milestone and Metrics: P-7 (P-7.1, P-7.2); P-X (P-X.1, P-X.2);
- Improvement Milestones and Metrics: I-X (I-X.1, I-X.2)
- Customizable Process Milestones and Metrics were chosen to specifically tailor their intent to the project process.

Unique community needs identification number the project addresses:
The project addresses the following unique community needs as identified in the community needs assessment:
- CN.2 – Inadequate access to specialty care
- CN.11 – High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with cancer
- CN.20 – Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
- CN.21 – Inadequate transportation options for individuals in rural areas and for indigent/low-income populations
• CN.22 – Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative: The expansion of Project VALET represents a significant expansion of current breast cancer screening programs by further reducing barriers to care such as access to screening services at low or no cost, language barriers, and lack of transportation. This includes both a geographic expansion and an increase in the number of clinics and women served.

Related Category 3 Outcome Measure(s):
OD-12 Primary Care and Primary Prevention
IT-12.6 Other Outcome Improvement Target: Women in need of diagnostic test(s)
• Numerator: Number of women who completed follow up/diagnostic test(s) with program partner(s)
• Denominator: Number of women referred for diagnostic test(s) with program partners
IT-12.6 Other Outcome Improvement Target: Women returning for an annual mammogram per recommended screening guidelines
• Numerator: Number of women ages 40 to 69, who return for their annual screening mammogram through Project VALET
• Denominator: Number of women ages 40 to 69, previously screened through Project VALET
IT-12.1 Breast Cancer Screening (HEDIS 2012)
• Numerator: Number of women, ages 40 to 69, who have received an annual mammogram during the reporting period. (TBD)
• Denominator: Number of women ages 40 to 69 in area, who meet Project VALET’s eligibility criteria

Reasons/Rationale for selecting the outcome measure(s):
The use of navigation services and promoting system changes in Category 2, is imperative in reaching the aforementioned outcome measures. For example, to increase the number of women who return for an annual screening mammogram, navigators will incorporate evidence-based reminder systems such as mailing postcards one month before their next annual screening mammogram. The MD Anderson Mobile Mammography Appointment line will also call women 24-hours prior to their scheduled mammogram. Both have been deemed as providing “strong evidence of their effectiveness in increasing breast cancer screening by mammography,” by The Guide to Community Preventive Services (14). These Cat 2 sources will create direct impact on IT-12.6 - Women in need of diagnostic test(s) and IT-12.6 - Women returning for an annual mammogram per recommended screening guidelines.

Providing free screening mammograms to uninsured, low income and Medicaid eligible women, who meet the screening criteria is a prevention strategy which removes the financial and transportation barriers that typically prevent these women from getting screened.

Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently referred to a program partner for diagnostic follow up by program navigators. Those with
confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm, and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.

Screening completion rates for low-income/indigent and minority women in RHP3 continue to fall below guidelines of the CDC initiative Healthy People 2020 of 81.1 percent (10). According to 2010 Texas Behavioral Risk Factor Surveillance System for PHR5S (which includes all the counties in RHP3 except for Calhoun), 74.9% of Black women, 72.5% of Hispanic women, and only 69.3% of white women ages 40 and over have had a mammogram within the past two years (11). For women in household earning less than $25,000 per year, 64.3% have had a mammogram within the past two years. Healthy People 2020’s target for the breast cancer death rate is 20.6 deaths per 100,000 females and it seeks to reduce late-stage diagnosis of breast cancer to 41.0 new cases per 100,000 females by 2020 (12). None of the counties in RHP3 has met this goal with the exception of Fort Bend County with 20.1 deaths per 100,000 for 2005-2009 (13).

Relationship to other Projects:
The project will support Goal 5, “Reducing the mortality of breast cancer in the Houston MSA,” one of the eight goals of the Comprehensive Cancer Control Program at The University of Texas MD Anderson Cancer Center.

Relationship to Other Performing Providers’ Projects in the RHP:
The increase of primary care and specialty care will naturally result in additional ambulatory care encounters for our region patient base. The ambulatory initiatives cover items such as laboratory, PT/OT, social work, etc. and are a necessity of our patients to ensure a comprehensive treatment for access as well as cost avoidance. The Region 3 initiative grid in the addendum reflects all ambulatory operations initiatives.

Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for the Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region’s health care system.

Project Valuation:
We have based our project valuation on California’s 1115 Medicaid Waiver model. As such, we have valued our projects at 2.5 times that of the estimated costs. Basing our valuations on California’s calculations we know we are well within the potential range of future cost savings when looking at the following from Prevention Institute and Trust for America’s Health Issue Report entitled Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities (July 2008):

- Prevention can reduce end-of-life costs by increasing health during the lifespan, what researchers call the compression of morbidity.
- There is a substantial return-on-investment in prevention – For every $1 invested in community-based prevention, the return amounts to $5.60.
**Unique Identifier:** 112672402.2.4  
**RHP PP Reference Number:** 2.7.1  
**Project Components:** 2.7.1  
**Project Title:** Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.) – Expansion of Project VALET of Screening Mammograms

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center  
**TPI -** 112672402

<table>
<thead>
<tr>
<th>Related Category 3</th>
<th>Outcome Measure(s):</th>
<th>Project Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>112672402.3.10</td>
<td>IT-12.6</td>
</tr>
<tr>
<td></td>
<td>112672402.3.11</td>
<td>IT-12.6</td>
</tr>
<tr>
<td></td>
<td>112672402.3.12</td>
<td>IT-12.1</td>
</tr>
<tr>
<td></td>
<td>IT-12.6 Other Outcome Improvement Target - Women in need of diagnostic test(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IT-12.6 Other Outcome Improvement Target - Women returning for an annual mammogram per recommended screening guidelines.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IT-12.1 Breast Cancer Screening (HEDIS 2012)</td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 1 [P-X]** Development of mobile mammography intervention for targeting uninsured, low income and Medicaid eligible women  
**Metric 1 [P-X.1]:** Order a digital mobile mammography van to ensure adequate frequency and reach  
**a. Baseline/Goal:** Baseline of 1 digital mobile mammography van/Goal of 2 digital mobile mammography vans  
**b. Data Source:** New mobile mammography schedule or other Performing Provider documents.  
**d. Rationale/Evidence:** Since the majority of their the Breast Clinic’s screening dates are reserved for long-standing corporate clients and clinics, the acquisition of a new mobile mammography van would enable Project VALET to increase its screening capacity, thus reaching uninsured, low income or Medicaid eligible women and expanding its geographic coverage to include neighboring clinics within the RHP3 area.

**Milestone 5 [P-X]:**  
Conduct bi-annual trainings with external clinic staff to ensure compliance with patient reporting  
**Metric 1 [P-X.1]:** staff training held in their respective clinic(s)  
**a. Baseline/Goal:** Baseline of two clinics with yearly training/Goal is to train staff at four additional clinics in the RHP3, twice yearly.  
**b. Data Source:** Training curricula and project records  
**c. Rationale/Evidence:** Training clinic staff is vital for them to be knowledgeable as to the eligibility process and program protocol; this will ensure that all documentation is consistently collected correctly and the program is run in a uniform manner.  
**Milestone 5 Estimated Incentive Payment:** 415,873.33

**Milestone 8 [P-X]:**  
Conduct bi-annual trainings with external clinic staff to ensure compliance with patient reporting  
**Metric 1 [P-X.1]:** Staff training held in their respective clinic(s)  
**a. Baseline/Goal:** Baseline of four clinics with training twice yearly/Goal is to train staff at two additional clinics in the RHP3, twice yearly.  
**b. Data Source:** Training curricula and project records  
**c. Rationale/Evidence:** Training clinic staff is vital for them to be knowledgeable as to the eligibility process and program protocol; this will ensure that all documentation is consistently collected correctly and the program is run in a uniform manner.

**Milestone 11 [P-X]:**  
Conduct bi-annual trainings with external clinic staff to ensure compliance with patient reporting  
**Metric 1 [P-X.1]:** staff training held in their respective clinic(s),  
**a. Baseline/Goal:** Baseline of six clinics with training twice yearly/Goal is to train staff at two additional clinics in the RHP3, twice yearly.  
**b. Data Source:** Training curricula and project records  
**c. Rationale/Evidence:** Training clinic staff is vital for them to be knowledgeable as to the eligibility process and program protocol; this will ensure that all documentation is consistently collected correctly and the program is run in a uniform manner.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 Estimated Incentive Payment:</strong> $696,811.50</td>
<td><strong>Milestone 6 [I-X]:</strong> Increase adherence/adoption of Project VALET protocol by participating clinic providers. Metric 1 [I-X.1]: Ensure the eligibility process is consistently completed correctly within each clinic. Metric 2 [I-X.2]: Ensure the referral process is consistently correctly instituted. Metric 3 [P-X.2]: Develop project infrastructure. Metric 1 [P-X.1]: Develop policies and</td>
<td><strong>Milestone 8 Estimated Incentive Payment:</strong> $461,202.00</td>
<td><strong>Milestone 11 Estimated Incentive Payment:</strong> $640,537.66</td>
</tr>
<tr>
<td><strong>Milestone 2 [P-X]:</strong> Train program staff. Metric 1 [P-X.1]: Train program staff. a. Baseline/goal: Baseline is 0/Goal is to hire and train one program manager and two part-time Community Health Workers (CHWs) to implement and manage program. b. Data Source: Program staff training curricula. c. Rationale/Evidence: The expansion of Project VALET necessitates a dedicated program manager as well as CHWs to serve as program navigators. <strong>Milestone 2 Estimated Incentive Payment:</strong> $696,811.50</td>
<td><strong>Milestone 7 [P-7]:</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. <strong>Milestone 12 [P-7]:</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</td>
<td><strong>Milestone 9 [P-7]:</strong> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</td>
<td><strong>Milestone 11 Estimated Incentive Payment:</strong> $640,537.66</td>
</tr>
<tr>
<td><strong>Milestone 3 [P-X]:</strong> Develop project infrastructure. Metric 1 [P-X.1]: Develop policies and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 6 Estimated Incentive Payment:</strong> $461,202.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Milestone 7 Estimated Incentive Payment:</strong> $640,537.66</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Unique Identifier:** 112672402.2.4  
**RHP PP Reference Number:** 2.7.1  
**Project Components:** 2.7.1  
**Project Title:** Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.) – Expansion of Project VALET of Screening Mammograms

<table>
<thead>
<tr>
<th>Performing Provider Name: The University of Texas MD Anderson Cancer Center</th>
<th>TPI - 112672402</th>
</tr>
</thead>
</table>

**Related Category 3**  
**Outcome Measure(s):**

- 112672402.3.10  
- 112672402.3.11  
- 112672402.3.12  
- IT.12.6  
- IT.12.6  
- IT.12.1  
- IT-12.6 Other Outcome Improvement Target - Women in need of diagnostic test(s)  
- IT-12.6 Other Outcome Improvement Target - Women returning for an annual mammogram per recommended screening guidelines.  
- IT-12.1 Breast Cancer Screening (HEDIS 2012)

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>

- **procedures**
  a. **Baseline/goal:** Baseline is 1 set of policies and procedures for existing program/Goal is to tailor 1 set of policies and procedures for each new clinic(s)/health system  
  b. **Data Source:** program documentation; memorandum of understanding; project records; process and procedures manual  
  c. **Rationale/Evidence:** Each clinic partner will vary in their protocol for implementing Project VALET, so the policies and procedures will need to be tailored to meet the clinics’ and patients’ needs.  

**Metric 2 [P-X.2]:** Marketing materials.

- **Develop marketing materials.**
  a. **Baseline/goal:** Baseline is 1 English and 1 Spanish Project VALET flier/Goal is to develop a new set of English and Spanish fliers that are tear-offs and post online information on the program.  
  b. **Data Source:** Process steps for project, training materials and completed marketing material.  
  c. **Rationale/Evidence:** Customizing print partners and that all documentation is completed correctly.

**Milestone 6 Estimated Incentive Payment:** $415,873.33

**Milestone 7 [P-7]:**
Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

**Metric 1 [P-7.1]:** Participate in semiannual face-to-face meetings or seminars organized by the RHP.  
- **Baseline/Goal:** Baseline of 0; Goal of 2 per year  
  **Data Source:** Documentation of semiannual meetings including meeting agendas and slides from presentations, and/or meeting notes.  
  **Rationale/Evidence:** Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” for performance across all providers.

**Metric 2 [P-7.2]:** Implement the “raise the floor” improvement initiatives established at the semiannual meeting.  
- **Baseline/Goal:** Baseline of 0; Goal of 2 per year  
  **Data Source:** Documentation of the “raise the floor” improvement initiatives agreed  

**Milestone 7 [P-7]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

**Metric 1 [P-7.1]:** Participate in semiannual face-to-face meetings or seminars organized by the RHP.  
- **Baseline/Goal:** Baseline of 0; Goal of 2 per year  
  **Data Source:** Documentation of semiannual meetings including meeting agendas and slides from presentations, and/or meeting notes.  
  **Rationale/Evidence:** Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” for performance across all providers.

**Metric 2 [P-7.2]:** Implement the “raise the floor” improvement initiatives established at the semiannual meeting.  
- **Baseline/Goal:** Baseline of 0; Goal of 2 per year  
  **Data Source:** Documentation of the “raise the floor” improvement initiatives agreed
### Project Title: Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.) – Expansion of Project VALET of Screening Mammograms

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center **TPI - 112672402**

**Related Category 3 Outcome Measure(s):**
- 112672402.3.10
- 112672402.3.11
- 112672402.3.12
- IT.12.6
- IT.12.6
- IT.12.1
- IT-12.6 Other Outcome Improvement Target - Women in need of diagnostic test(s)
- IT-12.6 Other Outcome Improvement Target- Women returning for an annual mammogram per recommended screening guidelines.
- IT-12.1 Breast Cancer Screening (HEDIS 2012)

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

and marketing material is essential in successfully promoting Project VALET.

**Milestone 3 Estimated Incentive Payment:** $929,082.00 $696,811.50

**Milestone 4 [P-7]:**
Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements.

**Metric 2 [P-7.2]:** Implement the “raise the floor” improvement initiatives established at the semiannual meeting.

**Metric 1 [P-7.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

a. Baseline/Goal: Baseline of 0; Goal of 2 per year

upon at each semiannual meeting and documentation that the participating provider implemented the “raise the floor” improvement initiative after the semiannual meeting

b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” and “raise the bar” for performance across providers.

**Milestone 9 Estimated Incentive Payment:** $61,202.00

**Milestone 12 Estimated Incentive Payment:** $640,537.66

**Milestone 13 [l-X]:** Increase adherence/adoption of Project VALET protocol by participating clinic providers.
**Unique Identifier:** 112672402.2.4  
**RHP PP Reference Number:** 2.7.1  
**Project Components:** 2.7.1  
**Project Title:** Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.) – Expansion of Project VALET of Screening Mammograms

<table>
<thead>
<tr>
<th>Performing Provider Name:</th>
<th>The University of Texas MD Anderson Cancer Center</th>
<th>TPI - 112672402</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 3</td>
<td>112672402.3.10</td>
<td>IT.12.6</td>
</tr>
<tr>
<td>Outcome Measure(s):</td>
<td>112672402.3.11</td>
<td>IT.12.1</td>
</tr>
<tr>
<td></td>
<td>112672402.3.12</td>
<td></td>
</tr>
</tbody>
</table>

**Outcome Measure(s):**
- IT.12.6 Other Outcome Improvement Target - Women in need of diagnostic test(s)
- IT.12.6 Other Outcome Improvement Target - Women returning for an annual mammogram per recommended screening guidelines.
- IT.12.1 Breast Cancer Screening (HEDIS 2012)

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Metric 1 [I-X.1]:** Ensure the eligibility process is consistently completed correctly within each clinic.
- Baseline/Goal: Baseline of eight clinics/Goal of two clinics
- Data Source: Medical record data and primary data collection
- Rationale/Evidence: This will ensure that all eligible patients are offered these services.

**Metric 2 [I-X.2]:** Ensure the referral process is consistently correctly instituted.
- Baseline/Goal: Baseline of eight clinics/Goal of two clinics
- Data Source: Medical record data and primary data collection
- Rationale/Evidence: Ensures that

**Year 2**
- **b. Data Source:** Documentation of semiannual meetings including meeting agendas and slides from presentations, and/or meeting notes.
- **b. Rationale/Evidence:** Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” for performance across all providers.

**Metric 2 [P-7.2]:** Implement the “raise the floor” improvement initiatives established at the semiannual meeting.
- **a. Data Source:** Documentation of the “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the “raise the floor” improvement initiative after the semiannual meeting
- **b. Rationale/Evidence:** Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” for performance across all providers.

**Year 3**
- **Milestone 7 Estimated Incentive Payment:** $415,873.33
- **b. Data Source:** Documentation of semiannual meetings including meeting agendas and slides from presentations, and/or meeting notes.
- **b. Rationale/Evidence:** Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” for performance across all providers.

**Metric 1 [I-X.1]:** Ensure the eligibility process is consistently completed correctly within each clinic.
- Baseline/Goal: Baseline of six clinics/Goal of two clinics
- Data Source: Medical record data and primary data collection
- Rationale/Evidence: This will ensure that all eligible patients are offered these services.

**Metric 2 [I-X.2]:** Ensure the referral process is consistently correctly instituted.
- Baseline/Goal: Baseline of six clinics/Goal of two clinics
- Data Source: Medical record data and primary data collection
- Rationale/Evidence: Ensures that
<table>
<thead>
<tr>
<th>Unique Identifier:</th>
<th>RHP PP Reference Number:</th>
<th>Project Components:</th>
<th>Project Title: Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.) – Expansion of Project VALET of Screening Mammograms</th>
</tr>
</thead>
<tbody>
<tr>
<td>112672402.2.4</td>
<td>2.7.1</td>
<td>2.7.1</td>
<td>Performing Provider Name: The University of Texas MD Anderson Cancer Center TPI - 112672402</td>
</tr>
</tbody>
</table>

**Related Category 3 Outcome Measure(s):**
- 112672402.3.10
- 112672402.3.11
- 112672402.3.12
- IT.12.6
- IT.12.6
- IT.12.1
- IT-12.6 Other Outcome Improvement Target - Women in need of diagnostic test(s)
- IT-12.6 Other Outcome Improvement Target- Women returning for an annual mammogram per recommended screening guidelines.
- IT-12.1 Breast Cancer Screening (HEDIS 2012)

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” and “raise the bar” for performance across providers.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 4 Estimated Incentive Payment:** $696,811.50

**Rationale/Evidence:** Ensures that women who need additional follow up will be correctly navigated to program partners and that all documentation is completed correctly.

**Milestone 10 Estimated Incentive Payment:** $461,202.00

**Milestone 13 Estimated Incentive Payment:** $640,537.66

**Year 2 Estimated Milestone Bundle Amount:** $2,787,246.00

**Year 3 Estimated Milestone Bundle Amount:** $1,247,620.00

**Year 4 Estimated Milestone Bundle Amount:** $1,383,606.00

**Year 5 Estimated Milestone Bundle Amount:** $1,921,613.00

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add milestone bundle amounts over Years 2-5): $7,340,085.00
University of Texas M.D. Anderson Cancer Center
Pass 2
Project Option 2.7.2 – Implement innovative evidence-based strategies to reduce tobacco use – Replicating Ask Advise Connect (AAC) in Federally-Qualified Health Centers

Unique RHP Project ID: 112672402.2.5/ PASS 2
Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402

Project Summary:
Provider: The University of Texas MD Anderson Cancer Center is a comprehensive cancer center ranked first in cancer care by U.S. News & World Report and dedicated to patient care, education, research and prevention. MD Anderson is comprised of several Texas Medical Center campus locations, two research campuses in Bastrop County, Texas, four regional care centers and a number of national and international divisions and affiliates. More than 108,000 people—almost one-third of them new patients—were seen in FY2011. MD Anderson provided $215 million in uncompensated charity care to Texans in FY2011.

Intervention(s): Ask Advise Connect (AAC) will be delivered in four Federally Qualified Health Centers (FQHCs) in Harris County by implementing clinical practice guidelines and promoting health system supports in electronic health records. In AAC, licensed vocational nurses and medical assistants are trained to ask all adult patients at every visit about their smoking status at the time that vital signs are assessed, provide brief advice to all smokers to quit, offer cessation assistance via the Quitline, and directly connect patients willing to accept assistance with the Quitline. Connections to the Quitline are made by clicking an automated link in the electronic health record (EHR) that sends smokers’ names and phone numbers to the Quitline within 24 hours. Patients are contacted by the Quitline within 48 hours of receipt of their contact information.

Need for the project: A) This project addresses Community Needs in RHP3: CN.11-High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease including: cancer, diabetes, obesity, cardiovascular disease, asthma, and AIDS/HIV; CN.12 – High rates of tobacco use and excessive alcohol use. B) An important component of the Patient Protection and Affordable Care Act (i.e., health care reform; ACA) is that information regarding tobacco use assessment and treatment be systematically tracked and recorded through electronic health records (EHR). Meaningful use criteria require clinicians to screen the smoking status of more than 50% of all unique patients who are 13 years old or older. This project does not receive funding from nor does it advance any federal initiatives pertaining to CMS Innovation Center Grants, HITECH payments, HRSA grants, SAMHSA funding and CDC (immunization grants or CLASBI/Hospital acquired infection) grants.

Target Population: Adult, medically underserved tobacco users within four selected FQHCs in Harris County. The nine FQHCs include a total of 25 primary care clinic sites and provide care to approximately 80,160 medically underserved individuals, a majority of whom are Medicaid-eligible/indigent.
Expected Reach for Implementation DY3:

<table>
<thead>
<tr>
<th>Patients</th>
<th>Percent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult patients at four FQHCs</td>
<td></td>
<td>23,111</td>
</tr>
<tr>
<td>Assessed for smoking status (Cat. 2)</td>
<td>50%</td>
<td>11,555</td>
</tr>
<tr>
<td>Current smokers</td>
<td>16.2%</td>
<td>1,871</td>
</tr>
<tr>
<td>Connected to Quitline (Cat. 2)</td>
<td>40%</td>
<td>748</td>
</tr>
<tr>
<td>Enroll in treatment (Cat. 3)</td>
<td>35%</td>
<td>261</td>
</tr>
<tr>
<td>Make a Quit Attempt (Cat. 3)</td>
<td>50%</td>
<td>130</td>
</tr>
<tr>
<td>Stay Quit at 6 Month Follow-up (Cat. 3)</td>
<td>28%</td>
<td>73</td>
</tr>
</tbody>
</table>

Category 1 or 2 expected patient benefits: The DY3 goals is to screen 50% of the adult patients receiving services at selected FQHCs and to connect 40% of eligible smokers to the Quitline. Screening in DY 4 will increase to 75%.

Category 3 outcomes: IT-11.6 Other Outcome Improvement Target (Smoking Cessation – Enroll in Treatment) – DY 4, 35% of Medicaid-eligible/indigent smokers will enroll in treatment with the Quitline; IT-11.6 Other Outcome Improvement Target (Smoking Cessation – Quit Attempts) – DY 4, 50% of Medicaid-eligible/indigent smokers enrolled in Quitline treatment will make a quit attempt; IT-11.6 Other Outcome Improvement Target (Smoking Cessation – Staying Quit) – DY4, 28% of Medicaid-eligible/indigent smokers enrolled in Quitline treatment will be abstinent at the time of follow-up.
Project Option 2.7.2 Implement innovative evidence-based strategies to reduce tobacco use
– Replicating Ask Advise Connect in Federally-Qualified Health Centers

Unique RHP Project Identification Number:  112672402.2.5 / Pass 2
Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402

Project Description: Smoking is the leading cause of preventable disease, disability, and death in the United States. Smoking cessation decreases the risk of lung cancer, other cancers, heart attack, stroke, and chronic lung disease. Although the health benefits of quitting smoking are substantial, quit rates are low. Furthermore, smokers with lower socioeconomic status tend to be less successful at quitting. Therefore, connecting underserved smokers with evidence-based cessation treatment such as treatment delivered by Quitlines is crucial for disease prevention and the elimination of tobacco-related health disparities.

The overarching goal of the proposed project, Replicating Ask Advise Connect (AAC), is to deliver evidence-based smoking cessation treatment to smokers seeking care in Federally-Qualified Health Centers (FQHC) in Harris County, Texas, and to ultimately reduce tobacco-related morbidity and mortality, particularly among individuals who are disproportionately burdened with the disease.

Associations Between Socioeconomic Status and Smoking. Smoking is becoming increasingly concentrated among individuals with the lowest levels of education, income, and occupational status. These smokers tend to have greater difficulty quitting. Further, low SES smokers are less likely to use effective resources for quitting and this phenomenon may partially explain why these smokers are less successful at quitting. Smoking is the single largest behavioral contributor to cancer and other diseases, and heavily accounts for a significant proportion of socioeconomic disparities in the incidence and mortality of cancer and other diseases. Thus, it is crucial that these smokers be provided with effective and accessible treatment.

Program overview. AAC is delivered through implementing clinical practice guidelines and promoting health system supports in electronic health records. In AAC, licensed vocational nurses and medical assistants are trained to ask all adult patients at every visit about their smoking status at the time that vital signs are assessed, provide brief advice to all smokers to quit, offer cessation assistance via the Quitline, and directly connect patients willing to accept assistance with the Quitline. Connections to the Quitline are made by clicking an automated link in the electronic health record (EHR) that sends smokers’ names and phone numbers to the Quitline within 24 hours. Patients are contacted by the Quitline within 48 hours of receipt of their contact information.

Quitline-Delivered Treatment. The Quitline is supported by the State of Texas Department of State Health Services and operated by Alere Wellbeing, Inc. It is staffed with trained cessation counselors available 24 hours a day, seven days a week. Counseling is available in English and Spanish, and can be provided in at least 15 additional languages through a third party. All smokers who enroll in cessation treatment receive the standard Guideline-based protocol along with access to nicotine replacement therapy. This includes up to five proactive counseling calls, each designed to help develop problem-solving and coping skills, secure social support, and plan for long-term abstinence. Follow up calls are timed to address smoking relapse. The call timing is flexible and adjusted as needed.
Community Partners. For this project, we will partner with the Harris County Healthcare Alliance (the Alliance), which coordinates efforts of safety-net clinics in Harris County. The Alliance will coordinate communication, EHR support, and data collection with participating FQHCs.

The proposed program builds upon a strong and established partnership with Harris Health System, The Texas Quitline, and Alere Wellbeing, and all partners will play substantial and integral roles in the program. Currently, AAC is being implemented in one FQHC, Good Neighbor Healthcare Center. Replication of the project to additional FQHCs will allow us to dramatically increase the number of smokers that are connected with evidence-based cessation treatment through implementing systems-level changes that will address both clinic- and patient-level barriers to connection with treatment through the use of an automated connection system. El Centro de Corazon is the first clinic that has agreed to implement AAC through the expansion effort.

Goal(s) and Relationship to Regional Goals(s): Aim 1: Disseminate a previously developed, evidence-based approach to linking smokers with cessation treatment in Federally-Qualified Health Centers.

Our goal is to work with up to four Federally Qualified Health Centers to disseminate Ask Advise Connect, a tested tobacco treatment program that utilizes systems level change and EHR to connect smokers to tobacco cessation treatment. If successful, our program will be readily implemented, maintained, and administered by the clinic sites and ultimately, disseminable to centers across the RHP.

Aim 2: Implement an evidence-based approach to linking smokers with cessation treatment among underserved persons receiving care at Federally-Qualified Health Centers.

Our goal is to screen, enroll, and connect smokers to smoking cessation treatment (standard Guideline-based treatment provided by the State Quitline) to smokers receiving care at FQHCs.

Aim 3: Evaluate the effectiveness of the smoking cessation treatment connection program implemented at FQHCs.

Our goal is to evaluate the following:

- **Reach** of the program - defined as the proportion of smokers who enroll in smoking cessation treatment through the program.
- **Efficacy** of the program - defined as the proportion of smokers who successfully quit smoking, assessed at 6 month follow-up.
- **Implementation** of the program – defined as: 1) proportion of patients screened for program eligibility; 2) proportion of patients contacted by Quitline; 3) proportion of patients enrolled in treatment, and 4) proportion of patients who successfully quit smoking.

Regional Goal. This proposed project is responsive to the first regional goal, “Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health outcomes and patient satisfaction.” At the present time, most FQHCs providing care to the underserved population in the greater Houston area do not systematically screen smoking status or record status in the EHR. However, smoking status and tobacco cessation are new healthcare
clinical measures that will be required for FQHCs to collect. Thus, the proposed project will fill an important gap by providing a systematic way to assess all patients’ smoking status, provide advice to quit, and connect patients to tobacco cessation treatment.

**Challenges:** Major challenges of the project include the following: 1) enrolling FQHCs to accept the intervention, 2) overcoming barriers to implement the intervention, and 3) offering a sustainable program. We have carefully considered each of these challenges in the design of the project. First, buy-in will be facilitated by our partnerships with the Alliance and with Good Neighbor Health Care Center. Specifically, the executive director at Good Neighbor, strongly supports this program and is committed to disseminating Ask Advise Connect to other FQHCs. Also, key collaborators at the Alliance will coordinate communication, data collection, and systems (EHR) improvements with FQHCs. Second, the approach itself has been tested in 10 Harris Health community clinics, 10 Kelsey Seybold Clinics, and one FQHC and can be tailored to the EHR systems and staffing plans of each clinic. The clinical staff provided critical input to the planning and implementation of the program. The program is intended to work within the existing vital signs and patient assessment procedures of each clinic and adds minimal time to existing practices. Also, MD Anderson program staff will provide on-site training and technical support needed to implement the intervention. Third, a crucial component of the project is the training of LVNs and medical assistants to screen for smoking status, provide advice to quit, connect patients to treatment, and log process in the EHR. This intervention provides a clinical systems change to consistently screen for smoking status and connect smokers to cessation treatment. The personnel resources and EHR changes will remain after the funding for the program ends. The program will ultimately meet the needs of the clinics to address tobacco cessation, a new healthcare clinical measure requirement of FQHCs.

**Five Year Expected Outcome for Provider and Patients:** We believe our program will: 1) enhance screening for smoking, 2) promote the delivery of evidence-based smoking cessation treatment, 3) reduce the prevalence of current smoking, and ultimately 4) reduce morbidity and mortality of smoking-related malignancies among FQHC patients.

**Starting Point/Baseline:** Patients will be recruited from the population of Medicaid eligible/indigent individuals receiving care at up to four Federally Qualified Health Centers. Preliminary discussions have identified Central Care, Good Neighbor, El Centro, and HOPE community health centers as potential partners. The total adult patient population at these centers is 23,111 (2011 UDS Reports).

Currently, smoking status is not systematically assessed, nor is cessation treatment offered.

Based on our group randomized trial conducted in 10 Harris Health Community Health Centers, 16.2% of patients are expected to be current smokers. Although our goal is to have the smoking status of all patients seeking care at the clinics assessed and recorded in the EHR, we believe that it is more realistic to estimate that 50% of patients will have their smoking status assessed and recorded in the EHR in DY 3. Screening will increase to 75% in DY 4. Therefore, we anticipate that in DY 3 11,555 patients will have their smoking status assessed and recorded in the EHR and that 1,871 (16.2%) of these individuals will be current smokers. All smokers will receive advice to quit smoking and will be offered connection with the Texas Quitline; 40% (748) will agree to be connected to the Quitline.
Based on results of the Harris Health study, it is anticipated that 35% (261) of the patients connected to the Quitline will enroll in Quitline-delivered treatment. Of patients enrolled in Quitline-delivered treatment, 50% (130) will make a quit attempt and 28% (73) will abstain at 6-month follow-up.

**Expected Reach for DY 3:**

<table>
<thead>
<tr>
<th>Patients</th>
<th>Percent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult patients at four FQHCs</td>
<td></td>
<td>23,111</td>
</tr>
<tr>
<td>Assessed for smoking status (Cat. 2)</td>
<td>50%</td>
<td>11,555</td>
</tr>
<tr>
<td>Current smokers</td>
<td>16.2%</td>
<td>1,871</td>
</tr>
<tr>
<td>Connected to Quitline (Cat. 2)</td>
<td>40%</td>
<td>748</td>
</tr>
<tr>
<td>Enroll in treatment (Cat. 3)</td>
<td>35%</td>
<td>261</td>
</tr>
<tr>
<td>Make a Quit Attempt (Cat. 3)</td>
<td>50%</td>
<td>130</td>
</tr>
<tr>
<td>Stay Quit at 6 Month Follow-up (Cat. 3)</td>
<td>28%</td>
<td>73</td>
</tr>
</tbody>
</table>

**Rationale:** Reasons for selection the project option: The Role of Healthcare Reform in Supporting the Sustainability of AAC. Recent policy initiatives have created a unique and historic opportunity to integrate and sustain the delivery of evidence-based tobacco treatments into healthcare settings. Specifically, the Patient Protection and Affordable Care Act (i.e., health care reform; ACA) has created payment incentives that address tobacco. A critically important component of this legislation is that information regarding tobacco use assessment and treatment be systematically tracked and recorded through electronic health records (EHR). Meaningful use criteria require clinicians to screen the smoking status of more than 50% of all unique patients who are 13 years old or older, as well as track the percentage of patients 18 and older who are current tobacco users, seen by a practitioner during the year, and receive advice, cessation treatments, or recommendations to use cessation medications and/or other strategies. As healthcare systems in Texas begin to implement systems to comply with meaningful use criteria regarding tobacco, referrals to the Texas Quitline are likely to increase dramatically. Unfortunately, without adequate infrastructure and financial support to treat these additional smokers, the Quitline is likely to become quickly overwhelmed and be unable to meet this increased demand for services.

Enhancing Widespread Adoption of Evidence-Based Smoking Cessation Treatment Delivered via the Texas Quitline. The past three decades have generated a tremendous amount of research and knowledge regarding how best to help smokers quit. These data indicate that the use of evidence-based cessation treatments can increase smoking abstinence rates as much as fourfold. However, far more attention and research dollars have been directed toward expansion of this knowledge base than to the dissemination and utilization of this knowledge. This lack of dissemination will ultimately diminish progress toward achieving critically important public health goals. Thus, the focus of this proposal is on increasing utilization of the Texas Quitline among smokers with the greatest need for assistance. Ask, Advise, Refer (AAR) is the recommended standard of care for linking smokers in healthcare settings with evidence-based cessation treatment. Although AAR is an improvement over previous strategies, we have developed, implemented, and maintained an even more effective strategy for providing a seamless linkage between health care systems and the Texas Quitline. Ask Advise Connect...
(AAC) utilizes the electronic health record (EHR) to systematically prompt clinicians to assess the smoking status of every patient at every visit, advise him/her to quit smoking, and directly and electronically link interested smokers with the Quitline. In a recently completed group randomized controlled trial among 10 Harris Health System community health clinics and over 113,000 patients, Quitline treatment uptake is 0.5% of all smokers seeking care at AAR clinics, vs. 14.7% among patients seeking care at AAC clinics, a 30-fold difference. To the best of our knowledge, this is the highest population level cessation treatment uptake reported to date. Similarly impressive results (0.6% in AAR clinics vs. 7.8% in AAC clinics) were found in a second recently completed group randomized controlled trial among 10 Kelsey Seybold clinics (a Houston based health care system that does not focus on the underserved).

**Project Components:** We believe our program will result in: 1) dissemination of an evidence-based smoking cessation program [P-X], 2) enhanced screening for smoking [P-X], 3) promote the delivery of evidence-based smoking cessation treatment [P-2], 4) reduce the prevalence of current smoking [IT-11.46], and ultimately 5) reduce morbidity and mortality of smoking-related malignancies in the FQHC patient population [IT-11.6].

**Milestones and Metrics:** The following milestones and metrics have been chosen for the Smoking Cessation Program for Underserved Persons receiving care at FQHCs:

- Process Milestones and Metrics: P-X (P-X.1, P-X.2); P-2 (P-2.1, P-2.2); P-7 (P-7.1, P-7.2)
- Improvement Milestones and Metrics: I-X (I-X.1, I-X.2); OD-11 (IT-11.6)

**Unique community need identification number the project addresses:** The project addresses the following unique community needs as identified in the community needs assessment:

- CN.11 – High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease including: cancer, diabetes, obesity, cardiovascular disease, asthma, and AIDS/HIV
- CN.12 – High rates of tobacco use and excessive alcohol use

**How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:**

MD Anderson tested AAC in 10 Harris Health System community health centers, 10 Kelsey Seybold clinics, and is currently implementing the program in Good Neighbor Healthcare Center. AAC was found to have from a 13- (Kelsey) to 30-fold (Harris Health) increase in smoking cessation treatment enrollment compared to AAR, the standard treatment. To the best of our knowledge, this is the highest population level cessation treatment uptake reported to date. This new initiative is to support widespread adoption of AAC to Federally-Qualified Health Centers, where it will have broad reach to medically-underserved smokers.

**Related Category 3 Outcome Measure(s):**

IT-11.6 Other Outcome Improvement Target (Smoking Cessation – Enroll in Treatment)

- DY 4, 35% of Medicaid eligible/indigent smokers will enroll in Quitline treatment

IT-11.6 Other Outcome Improvement Target (Smoking Cessation – Quit Attempts)

- DY 4, 50% of Medicaid eligible/indigent smokers enrolled in Quitline treatment will make a quit attempt
IT-11.6 Other Outcome Improvement Target (Smoking Cessation – Staying Quit)

- DY 4, 28% of Medicaid eligible/indigent smokers enrolled in Quitline treatment will be abstinent at the time of follow-up

**Reasons/rationale for selecting the outcome measure(s):** The selected Category 3 Outcome Measure directly addresses the Regional Health Plan Community Needs CN.12 – High rates of tobacco use, and would capture reduction in tobacco use among smokers in participating FQHCs. Aim 3 of the program is to evaluate the effectiveness of the smoking cessation program implemented at FQHCs. The reach, efficacy, and impact of AAC will be evaluated using the RE-AIM conceptual framework. RE-AIM provides a systematic way to evaluate the impact of the dissemination and implementation of public health interventions and includes five criteria: reach, efficacy, adoption, implementation, and maintenance. **Reach** is defined as the number of smokers visiting the clinics that talked with the Quitline / total number of smokers that visited the clinics. **Efficacy** is defined as the total number of smokers visiting the clinics that enrolled in treatment with the Quitline / total number of smokers that visited the clinics. **Impact** is defined as Reach x Efficacy.

**Replication.** A major consideration that guided the conceptualization and development of the Ask Advise Connect model was that it has the potential to make a significant public health impact. Because we are delivering the approach in community clinics that provide care to underserved, primarily racial/ethnic minority patients with low socioeconomic status, our dissemination setting is representative of real-world population-based tobacco control settings and has broad reach. In addition, the dissemination approach is intended to be delivered by clinical providers using the EHR. Third, the approach has been designed to greatly streamline the process of connecting smokers interested in quitting with the Quitline in order to shift the burden of counseling from clinical providers to the Quitline. In contrast to providing counseling in the clinic setting, connecting smokers with proactive telephone counseling via the Quitline is convenient, eliminates transportation time and costs, entails no childcare costs, is more acceptable to patients than face-to-face counseling, reduces the burden on physicians and other members of the health care team, and has demonstrated strong efficacy. Importantly, our approach could be feasibly and cost-effectively implemented in numerous population-based settings for tobacco control (e.g., clinics, hospitals, dentist offices), the environments where quitlines would be most likely to be disseminated and implemented. Taken together, each of these factors is important and all are intended to ensure that the dissemination approach could be easily adopted in other public health settings.

**Relationship to other Projects:** By delivering an evidenced based smoking cessation program Medicaid-eligible/indigent smokers in FQHCs, this program is in line with the RHP. Unique RHP Project ID Number 112672402.2.2 provides a similar smoking cessation project in one FQHC, tailored to persons living with HIV/AIDS. Unique RHP Project ID Number 112672402.2.4 Expand Project VALET will work in partnership with FQHCs to provide mammography screening. Also, all RHP project teams work in collaboration with the Comprehensive Cancer Control Program at MD Anderson.

**Relationship to Other Performing Providers’ Projects in the RHP:** Innovation is key to the transformation of healthcare in our community. The consistency of innovation in our region allows for increased improvements based on research trends, patient need, and provider
availability. The waiver funding allows for innovation in specific areas and all innovative projects included in the plan are similar in the fact of program redesigns for historic treatments, and focus to chronic condition outcome measures such as central line infections. The Region 3 initiative grid in the addendum can provide a side by side comparison of all projects that directly relate to innovation.

**Plan for Learning Collaborative:** We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for RHP3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

**Project Valuation:** We have based our project valuation on California’s 1115 Medicaid Waiver model. As such, we have valued our projects at 2.5 times that of the estimated costs. Basing our valuations on California’s calculations we know we are well within the potential range of future cost savings when looking at the following from Prevention Institute and Trust for America’s Health Issue Report entitled *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities (July 2008)*:

- Prevention saves money – an investment of $10 per person per year in programs to increase physical activity, improve nutrition, and prevent tobacco use could save the country more than $16 billion in annual health care costs within five years.
- Prevention can reduce end-of-life costs by increasing health during the lifespan, what researchers call the *compression of morbidity*.

There is a substantial return-on-investment in prevention – For every $1 invested in community-based prevention, the return amounts to $5.60.
**UNIQUE IDENTIFIER:** 112672402.2.5  
**RHP PP REFERENCE NUMBER:** 2.7.2  
**PROJECT COMPONENTS:** 2.7.2  
**Project Title:** Implement innovative evidence-based strategies to reduce tobacco use - Replicating Ask Advise Connect in Federally-Qualified Health Centers

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

<table>
<thead>
<tr>
<th>Year</th>
<th>Milestones</th>
</tr>
</thead>
</table>
| **Year 2** (10/1/2012 – 9/30/2013) | Milestone 1 [P-X]: Enroll up to four FQHCs to disseminate AAC.  
**Metric 1 [P-X.1]:** Document subcontracts/agreements; Number of FQHCs enrolled.  
**Baseline/Goal:** At present, primary care FQHCs do not systematically offer a proactive, evidence-based smoking cessation intervention. Currently we are implementing AAC in only one clinic. Our goal is to partner with up to four FQHCs to deliver AAC.  
**Rationale:** AAC supports clinical practice guidelines and has shown to be effective in connecting smokers to cessation treatment.  
**Data Source:** Subcontracts/agreements with FQHCs  
**Milestone 1 Estimated Incentive** |
| **Year 3** (10/1/2013 – 9/30/2014) | Milestone 4 [P-X]: Identify prevalence of current smoking among adult Medicaid eligible/indigent patients receiving services at selected FQHCs, by screening for smoking status.  
**Metric 1 [P-X.1]:** Screen 75% 50% of adult patients  
**Baseline/Goal:** At present, smoking status is not documented systematically. Our goal is to document smoking status among 75 50% of adult patients (N=11,555).  
**Data Source:** EHR data and primary data collection.  
**Rationale:** Affordable Care Act meaningful use criteria require clinicians to screen 50% of all unique patients 13 and older. We |
| **Year 4** (10/1/2014 – 9/30/2015) | Milestone 7 [P-X]: Identify prevalence of current smoking among Medicaid eligible/indigent adult patients receiving services at selected FQHCs, by screening for smoking status.  
**Metric 1 [P-X.1]:** Screen 75% of adult patients  
**Baseline/Goal:** At present, smoking status is not documented systematically. Our goal is to document smoking status among 75% of adult patients (N=17,333).  
**Data Source:** EHR data and primary data collection.  
**Rationale:** Affordable Care Act meaningful use criteria require clinicians to screen 50% of all unique patients 13 and older. We |
| **Year 5** (10/1/2015 – 9/30/2016) | Milestone 11 [P-7]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.  
**Metric 1 [P-7.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.  
**Baseline/Goal:** Goal is for staff to participate in at least two face-to-face meetings.  
**Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.  
**Rationale:** Investment in learning and sharing of ideas is central to |
**Project Title:** Implement innovative evidence-based strategies to reduce tobacco use - Replicating Ask Advise Connect in Federally-Qualified Health Centers

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Payment:** $394,531.33

**Milestone 2 [P-2]:** Implement evidence-based, innovative project for target population

**Metric 1 [P-2.1]:** Program EHR systems for data collection and reporting.

**Baseline/Goal:** Presently, FQHCs do not have tobacco screening, education, and treatment systematically documented in EHR. Our goal is to program EHR systems to document screening for smoking status and data collection for education and treatment offered.

**Data Source:** Documentation of enhancements to EHR systems

**Rationale:** AAC provides systems enhancements to electronic health records to capture data required

**Metric 2 [P-2.1]:** Document implementation strategy; Enroll and deliver smoking cessation treatment to 15% of eligible Connect 40% of Medicaid eligible/indigent smokers to the state Quitline. screened at participating FQHCs.

**Baseline/Goal:** Our goal is to connect 15 40% of eligible smokers to the Quitline (N=748).

**Data Source:** EHR and Alere databases.

**Rationale:** Based on previous studies with Harris Health, 40% of smokers were connected to the Quitline. Since FQHCs have a

**Milestone 4 Estimated Incentive Payment:** $401,747.00

**Milestone 5 [P-2]:** Implement evidence-based, innovative project for target population

**Metric 1 [P-2.1]:** Document implementation strategy; Enroll and deliver smoking cessation treatment to 15% of eligible Connect 40% of Medicaid eligible/indigent smokers to the state Quitline. screened at participating FQHCs.

**Baseline/Goal:** Our goal is to connect 15 40% of eligible smokers to the Quitline (N=1,122).

**Data Source:** EHR and Alere databases.

**Rationale:** Based on previous studies with Harris Health, 40% of smokers were connected to the Quitline. Since FQHCs have a

**Milestone 7 Estimated Incentive Payment:** $308,577.75

**Milestone 8 [P-2]:** Implement evidence-based, innovative project for target population

**Metric 1 [P-2.1]:** Connect 40% of Medicaid eligible/indigent smokers to the state Quitline.

**Baseline/Goal:** Our goal is to connect 15 40% of eligible smokers to the Quitline (N=1,122).

**Data Source:** EHR and Alere databases.

**Rationale:** Based on previous studies with Harris Health, 40% of smokers were connected to the Quitline. Since FQHCs have a

**Milestone 9 [P-2.2]:** Implement the “raise the floor” improvement initiatives established at the semiannual meeting.

**Baseline/Goal:** Goal is for staff to implement required “raise the floor” improvement initiatives.

**Data Source:** Documentation of “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider
### Project Components:

**Project Title:** Implement innovative evidence-based strategies to reduce tobacco use - Replicating Ask Advise Connect in Federally-Qualified Health Centers

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**Related Category 3 Outcome Measure(s):**

- 112672402.3.13
- 112672402.3.14
- 112672402.3.15
- IT-11.6
- Other Outcome Improvement Target (Smoking Cessation – Enroll in Treatment)
- Other Outcome Improvement Target (Smoking Cessation – Quit Attempts)
- Other Outcome Improvement Target (Smoking Cessation – Staying Quit)

### Year 2

(10/1/2012 – 9/30/2013)

- **Metric 2 [P-2.2]:** Document implementation strategy; Train staff and implement AAC procedures.
  - **Baseline/Goal:** Front-line staff in FQHCs do not have standard procedures for screening and documenting smoking status and referral to treatment. Goal is to train staff to deliver AAC at intake.
  - **Data Source:** Documentation of training and booster trainings.
  - **Rationale:** Training is required to teach staff new AAC procedures, informed consent, and EHR enhancements.
  - **Estimated Incentive Payment:** $394,531.33

### Year 3

(10/1/2013 – 9/30/2014)

- **Metric 1 [P-7.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.
  - **Baseline/Goal:** Goal is for staff to participate in at least two face-to-face meetings.
  - **Data Source:** Documentation of adherence.
  - **Rationale:** Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” and “raise the bar” for performance across providers.

### Year 4

(10/1/2014 – 9/30/2015)

- **Metric 1 [P-7.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.
- **Baseline/Goal:** Goal is for staff to participate in at least two face-to-face meetings.
- **Data Source:** Documentation of adherence.

### Year 5

(10/1/2015 – 9/30/2016)

- **Metric 2 [P-2.2]:** Document implementation strategy; Train staff and implement AAC procedures.
  - **Baseline/Goal:** Based on previous studies with Harris Health, 40% of smokers were connected to the Outlines. Since FQHCs have a similar, Medicaid-eligible/indigent population, we expect similar results.
  - **Data Source:** Documentation of training and booster trainings.
  - **Rationale:** Training is required to teach staff new AAC procedures, informed consent, and EHR enhancements.

- **Estimated Incentive Payment:** $308,577.75

### Milestone 8 Estimated Incentive Payment:

- **Amount:** $308,577.75

### Milestone 9

- **Metric 1 [P-7.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP.
- **Baseline/Goal:** Goal is for staff to participate in at least two face-to-face meetings.
- **Rationale:** Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” and “raise the bar” for performance across providers.

- **Estimated Incentive Payment:** $632,126.50

### Milestone 12 [I-X] Increase adoption of Ask Advise Connect protocol by participating FQHC providers.

- **Metric 1 [I-X.1]:** Intermediate: Increased adherence to Ask Advise and Connect guidelines by providers.
<table>
<thead>
<tr>
<th>UNIQUE IDENTIFIER: 112672402.2.5</th>
<th>RHP PP REFERENCE NUMBER: 2.7.2</th>
<th>PROJECT COMPONENTS: 2.7.2</th>
<th>Project Title: Implement innovative evidence-based strategies to reduce tobacco use - Replicating Ask Advise Connect in Federally-Qualified Health Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing Provider Name: The University of Texas MD Anderson Cancer Center</td>
<td>TPI - 112672402</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 3 Outcome Measure(s):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Milestone 3 [P-7]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline/Goal: Goal is for staff to participate in at least two face-to-face meetings.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rationale: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” for performance across all providers.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 2 [P-7.2]: Implement the “raise the floor” improvement initiatives established at the semiannual meeting.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline/Goal: Goal is for staff to implement required “raise the floor” semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rationale: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” for performance across all providers.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 12 Estimated Incentive Payment: $632,126.50</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Project Title: Implement innovative evidence-based strategies to reduce tobacco use - Replicating Ask Advise Connect in Federally-Qualified Health Centers

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**Project Components:**
- 2.7.2

**Outcome Measure(s):**
- 112672402.3.13
- 112672402.3.14
- 112672402.3.15
- IT-11.6
- IT-11.6
- IT-11.6
- Other Outcome Improvement Target (Smoking Cessation – Enroll in Treatment)
- Other Outcome Improvement Target (Smoking Cessation – Quit Attempts)
- Other Outcome Improvement Target (Smoking Cessation – Staying Quit)

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Metric 2 [P-7.2]:** Implement the “raise the floor” improvement initiatives established at the semiannual meeting.

**Baseline/Goal:** Goal is for staff to implement required “raise the floor” improvement initiatives. **Data Source:** Documentation of “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the “raise the floor” improvement initiative after the semiannual meeting. **Rationale:** Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” and “raise the bar” for performance across providers. **Milestone 6 Estimated Incentive Payment:** $401,747.00

**Metric 3 [P-7.2]:** Implement development of “raise the floor” improvement initiatives.

**Baseline/Goal:** Goal is for staff to implement required “raise the floor” improvement initiatives. **Data Source:** Documentation of “raise the floor” improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the “raise the floor” improvement initiative after the semiannual meeting. **Rationale:** Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” and “raise the bar” for performance across providers. **Milestone 9 Estimated Incentive Payment:** $308,577.75
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Project Title:** Implement innovative evidence-based strategies to reduce tobacco use - Replicating Ask Advise Connect in Federally-Qualified Health Centers

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**Project Components:**
- IT-11.6
- IT-11.6
- Other Outcome Improvement Target (Smoking Cessation – Enroll in Treatment)
- Other Outcome Improvement Target (Smoking Cessation – Quit Attempts)
- Other Outcome Improvement Target (Smoking Cessation – Staying Quit)

**Milestone 3 Estimated Incentive Payment:** $394,531.33

Improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to “raise the floor” and “raise the bar” for performance across providers.

**Metric 1 [I-X.1]** Short term: Increased adoption of new Ask Advise Connect guidelines by providers

Baseline/Goal: Goal is for participating clinics to systematically adopt implementation of Ask Advise Connect. Baseline is 1 clinic, goal is to replicate AAC in 4 clinics.

Data Source: Medical record reports and primary data collection, i.e. documentation of booster trainings

Rationale: Systems change/systems delivery improvement is essential for
<table>
<thead>
<tr>
<th>UNIQUE IDENTIFIER:</th>
<th>RHP PP REFERENCE NUMBER:</th>
<th>PROJECT COMPONENTS:</th>
<th>Project Title:</th>
<th>Performing Provider Name:</th>
<th>TPI - 112672402</th>
</tr>
</thead>
<tbody>
<tr>
<td>112672402.2.5</td>
<td>2.7.2</td>
<td>2.7.2</td>
<td>Implement innovative evidence-based strategies to reduce tobacco use - Replicating Ask Advise Connect in Federally-Qualified Health Centers</td>
<td>The University of Texas MD Anderson Cancer Center</td>
<td></td>
</tr>
</tbody>
</table>

**Outcome Measure(s):**

- 112672402.3.13
- 112672402.3.14
- 112672402.3.15
- IT-11.6
- IT-11.6
- IT-11.6
- Other Outcome Improvement Target (Smoking Cessation – Enroll in Treatment)
- Other Outcome Improvement Target (Smoking Cessation – Quit Attempts)
- Other Outcome Improvement Target (Smoking Cessation – Staying Quit)

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>complying with Affordable Care Act requirements.</td>
<td>Milestone 10 Estimated Incentive Payment: $308,577.75</td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $1,183,594.00</td>
<td>Year 3 Estimated Milestone Bundle Amount: $1,205,241.00</td>
<td>Year 4 Estimated Milestone Bundle Amount: $1,234,311.00</td>
<td>Year 5 Estimated Milestone Bundle Amount: $1,264,253.00</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $4,887,399.00
Project Option-2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: Expand Senior Care Capacity at West Houston

Unique RHP Project Identification Number: 094187402.2.1
Performing Provider Name/TPI: HCA - West Houston Medical Center TPI/094187402

- **Provider**: West Houston Medical Center is a 276-bed facility in Houston, Texas. The facility is located in the Houston-Sugarland-Baytown MSA, which serves a population of approximately 6,000,000 people.

- **Intervention(s)**: HCA intends to improve the patient throughput, overall experience and quality of care for geriatric patients. Specifically, HCA will create a designated “Senior Care Entrance” at the hospital and assign special hospital beds to accommodate the geriatric population. Additionally, HCA will train and maintain a Senior Care Coordinator dedicated to overseeing protocol-driven geriatric care. The Senior Care Coordinator will assist seniors in managing their appointments, maintaining their individual healthcare regimens, and accessing available support through the hospital and the community. In addition to guiding the patient through the healthcare system, in DY4 and DY5, HCA will focus on ensuring that patients without a PCP are given educational materials about available resources in the community. This will enable patients to receive the appropriate care in the appropriate setting – a main focus of the Waiver.

- **Need for the project**: Geriatric patient populations face unique challenges in obtaining care, and those challenges must be addressed in order for geriatric patients to have effective access to care. Harris County Hospital District’s DSRIP work groups have identified expanding access to care for seniors as a priority for the region. These patients are often on a fixed income, may have increased problems with mobility, memory, and technological ability which inhibit their ability to effectively access care.

- **Target population**: The target population of this project is geriatric patients in the community and surrounding areas, particularly those patients who are currently unable to access to care effectively. West Houston Medical Center experiences approximately 15,000-16,000 patient encounters with geriatric patients per year (with geriatric defined as ≥ 65 years or older). Of the geriatric patients treated, 20-26% are Medicaid-eligible or uninsured. Thus, while this project will benefit all geriatric patients at the hospital, 20-26% of the benefit will affect Medicaid and uninsured geriatric patients.

- **Category 1 or 2 expected patient benefits**: HCA will improve geriatric patients’ experience at its facility, and improve short- and long-term patient outcomes, by assisting these patients in navigating the often fractured and confusing healthcare continuum.
  - **DY2**: HCA does not expect direct patient benefit in DY2, as HCA will be implementing the patient navigation program, hiring personnel, and developing procedures and protocols for the program.
  - **DY3**: HCA expects that about 730 patients will benefit from the patient navigator program, most of whom are likely to be Medicaid-eligible or uninsured.
  - **DY4**: patient impact of about 2,075 patients in DY4, and about
  - **DY5**: about 4,150 patients.
• **Category 3 outcomes:** IT 3.1 – Through this project, West Houston will reduce the number of Potentially Preventable Readmissions (PPRs) for geriatric patients, indicating improved health outcomes and patient quality of life. PPRs are disruptive and often have a substantial impact on a patient’s chance of long-term recovery, and PPRs add hefty additional costs to the healthcare delivery system that can be prevented through improved access to primary and preventative care.

**Project Description:**
Through implementing this project, HCA intends to improve the patient throughput, overall experience and quality of care for geriatric patients. Geriatric patients will benefit from the dedicated care designed to meet the needs of patients greater than 65 years of age who live in West Houston’s primary and secondary zip codes (77072, 77082, 77083, 77036, 77042, 77077, 77094, 77099, 77450) located in Harris County. This dedicated care includes unique components to address both environmental and clinical service needs. Specifically, HCA will create a designated “Senior Care Entrance” at the hospital and assign special hospital beds which are designed to accommodate the geriatric population. Additionally, HCA will train and maintain a Senior Care Coordinator dedicated to overseeing protocol-driven geriatric care, which will be developed with input from facility geriatricians, and close communication with local SNFs, LTACs, and nursing homes to assure solid continuity of care. The Senior Care Coordinator will assist seniors in managing their appointments, maintaining their individual healthcare regimens, and accessing available support through the hospital and the community.

**Goal(s) and relationship to Regional goal(s):**

**Project goals:**
HCA hopes to improve geriatric patients’ experience as inpatients and outpatients at its facility, and to improve short- and long-term patient outcomes by assisting these patients in navigating the often fractured and confusing healthcare continuum. Specifically, by enabling geriatric patients to access the care they need, which is tailored to their needs. In addition to guiding the patient through the healthcare system, this project also seeks to match geriatric patients that do not have access to a primary care provider with a provider in the community. In DY4 and DYS HCA will focus on ensuring that patients without a PCP are given educational materials about available resources in the community.

**This project meets the following Region 3 goals:**
While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
• Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

• Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and

• Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

Challenges and how addressed:

• Identifying a qualified Senior Care Coordinator and training that person in geriatric-specific care needs and protocols – HCA will recruit and retain an individual who is qualified to navigate the healthcare continuum and will provide training for geriatric specific services.

• Need for community and provider education regarding the dedicated Senior Care services and geriatric protocols – HCA will address this challenge by training the Senior Care Coordinator to work with providers inside and outside of the hospital and prove the efficacy of managing seniors’ health on a consistent basis, as opposed to providing episodic care with little to no support.

• Educating patients and encouraging participation in the program – HCA will address this challenge by having the Senior Care Coordinator and other providers within the hospital explain the program to patients prior to enrollment.

5-year expected outcome for provider and patients:
HCA hopes to decrease the number of geriatric patients without a primary care provider who received education about a primary care provider in the ED, and accomplish a reduction in ED readmissions by patients enrolled in the navigator program by the end of the Waiver, as a result of increased preventative and managed care prior to seniors’ conditions reaching an acute or emergent stage.

Starting Point/Baseline:
West Houston Medical Center does not currently provide patient navigation services to its geriatric patients. The hospital will establish a baseline of the number of total geriatric patients visiting the ED in DY2, in order to measure progress going forward.

Rationale:
Geriatric patient populations face unique challenges in obtaining care, and those challenges must be addressed in order for geriatric patients to have effective access to care. Harris County
Hospital District’s DSRIP work groups have identified expanding access to care for seniors as a priority for the region (see “DSRIP Initiative Prioritization/Ranking,” item 71).

Patient navigators assist patients and their families in navigating the fragmented maze of doctors’ offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system. Services provided by patient navigators vary by program and the needs of the patient, but often include:

- Facilitating communication among patients, family members, survivors and healthcare providers.
- Coordinating care among providers.
- Arranging financial support and assisting with paperwork.
- Arranging transportation.
- Ensuring that appropriate medical records are available at medical appointments.
- Facilitating follow-up appointments.
- Community outreach and building partnership with local agencies and groups.
- Ensuring access to clinical trials.

Access to the above services is especially imperative for senior patients, as they are often on a fixed income, may have increased problems with mobility, memory, and technological savvy. The Senior Care Coordinator can assist seniors in confronting the challenges associated with access necessary healthcare, in order to prevent the deterioration of otherwise manageable conditions and to improve the quality of life for seniors.

**Project Components:**

HCA will address the project components as follows:

a. **Identify frequent ED users and use navigators as part of a preventable ED reduction program.** Train health care navigators in cultural competency. HCA has identified geriatric patients as a patient population with high rates of ED users. The Senior Care Coordinator will target inpatient seniors for education and intervention aimed at preventing future ED use for non-emergent conditions and/or preventing conditions from becoming emergent in the first place.

b. **Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.** HCA will recruit and retain a qualified health worker to be the Senior Care Coordinator, with special consideration for candidates who have experience working with the senior community.
c. **Connect patients to primary and preventive care.** The Senior Care Coordinator’s main function will be to assist seniors in making primary and preventative care appointments, determining the assistance necessary to help seniors keep those appointments, and to work with seniors and their families to assure that their access to support (financial, transportation, in-home care, etc) is adequate.

d. **Increase access to care management and/or chronic care management, including education in chronic disease self-management.** Currently, senior patients at the hospital do not have access to a dedicated care coordinator to assist in self-management education and chronic care management. The Senior Care Coordinator will be dedicated to providing those services.

e. **Conduct quality improvement for project using methods such as rapid cycle improvement.** Activities may include, but are not limited to, identifying project impacts, identifying “lessons learned,” opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. As part of Milestone 5, HCA will participate in learning collaboratives with other Performing Providers engaging in Care Navigation to share lessons learned, identify best practices, and discuss key challenges.

**Unique community need identification number the project addresses:**

- CN.1 - Inadequate access to primary care
- CN.6 - Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly
- CN.7 - Insufficient access to care coordination practice management and integrated care treatment programs
- CN.8 - High rates of inappropriate emergency department utilization
- CN.9 - High rates of preventable hospital readmissions
- CN.10 - High rates of preventable hospital admissions
- CN.11 - High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including: Cancer, Diabetes, Obesity, Cardiovascular disease, Asthma, AIDS/HIV
- CN. 20 - Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
- CN.23 - Lack of patient navigation, patient and family education and information programs

**How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:**

Currently, West Houston Medical Center does not provide patient navigation services for the senior population, thus this project is a brand-new initiative for this hospital.
**Related Category 3 Outcome Measures:** OD-3 Potentially Preventable Re-Admissions; IT 3.1 All cause 30 day readmission rate – NQF 1789 (for patients enrolled in care navigation services).

**Reasons/rationale for selecting the outcome measure(s):**

HCA chose this Category 3 Outcome because one of the important goals behind implementing the Senior Care Coordination program is to reduce the number of PPRs, which should be indicative of improved health outcomes and patient quality of life. PPRs are disruptive and often have a substantial impact on a patient’s chance of long-term recovery, and PPRs add hefty additional costs to the healthcare delivery system that should be preventable through improved access to primary and preventative care. Additionally, through reducing PPRs, a larger goal of getting the patient appropriate care in the appropriate setting is accomplished. Many patients do not have a primary care provider, or information, or access to an ambulatory setting. As part of this project, HCA West Houston will focus on increasing awareness of community resources so that patients in these vulnerable populations can seek care in a more appropriate venue.

**Relationship to Other Projects:** This project is part of HCA’s larger plan of expanding and developing specialty services along with delivery improvements targeted to particular populations (e.g., OB/GYN patients and behavioral health patients), while improving access to care.

**Relationship to Other Performing Providers’ Projects in the RHP:** The increased access to primary care visits will naturally generate additional need of specialty care visits based on the condition and acuity of the patients served. Understanding that the patient base targeted through this initiative will generate significant specialty care visits due to chronic conditions and lack of previous treatments, this initiative and similar initiatives will focus to 30-day readmission rate reductions, improvement for patient satisfaction scores, and admission rates specific to chronic conditions. Numerous initiatives have been included in the RHP plan and the addendum of the Initiative Grid can directly tie all specialty care projects together by category.

**Plan for Learning Collaborative:** We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

**Project Valuation:**

**Approach for valuing project:** The valuation of each HCA project takes into account the degree to which the project accomplishes the triple-aim of the Waiver: community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project.
**Rationale for project valuation:** Specifically, the valuation of this project incorporates the need for improved access to care and quality of care among Region 3 geriatric patient populations, and the potential for sustainable improvement in this area as a result of implementing this project. This project will require development of standardized protocols and procedures for identifying, tracking, and following up with geriatric patients. This project, a global system to improve outcomes for geriatric patients, many of whom have difficulty accessing care due to illness, will require training to ensure that personnel are prepared to assist in the unique needs of the elderly population. HCA will also be hiring at least one dedicated patient navigator for this program, and train a significant number of current staff to provide higher quality care. The valuation also takes accounts for the emphasis that the Region 3 DSRIP work groups have placed on the expansion of access to care for seniors. In addition to patient benefits, projects that seek to increase access to ambulatory health care settings will result in an overall cost-savings to the healthcare delivery system. It is clear that the rising costs of healthcare must be curbed to maintain a stable delivery system. Region 3 is focused on getting patients out of the ED for non-acute conditions, and ensuring that each patient has the information and referrals necessary to be seen at a community primary care provider.
<table>
<thead>
<tr>
<th>HCA – West Houston Medical Center</th>
<th>094187402</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: Expand senior care capacity at West Houston</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Related Category 3**

**Outcome Measure(s): OD-3**

<table>
<thead>
<tr>
<th>094187402.3.1</th>
<th>IT-3.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cause 30 day readmission rate (for patients enrolled in care navigation program).</td>
<td></td>
</tr>
</tbody>
</table>

| Year 2 (10/1/2012 – 9/30/2013) | Milestone 1 [P-2]: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education.  
Metric 1 [P-2.1]: Number of people trained as patient navigators  
Baseline/goal: to recruit, retain, and train one (1) Senior Care Coordinator, dedicated to providing navigation services to geriatric patients  
Data Source: Patient Navigation program materials  
Estimated Baseline: In 2012, the facility had about 41,000 Medicare, Medicaid and Self-pay geriatric presentations in the ED.  
Milestone 1 Estimated Incentive Payment (maximum amount): $3,222,996 |
| Milestone 2 [P-3]: Provide care/management/navigation services to targeted patients.  
Metric 1 [P-3.1]: Increase in the percent of targeted patients enrolled in the program  
Baseline/goal: accomplish enrollment of at least 10% of geriatric patients identified at the West Houston facility  
Data source: Enrollment reports |
| Milestone 2 Estimated Incentive Payment: $1,758,058 |
| Milestone 3 [P-X1]: Establish a baseline  
Metric [P-X1.1]: ED visits and/or hospitalizations  
Goal: establish a baseline number of ED visits and/or avoidable hospitalizations for patients initially enrolled in the care navigation program during DY 3, in order to measure progress going forward.  
Data source: EHR, navigation program database, ED records, inpatient records |
| Milestone 3 Estimated Incentive Payment: $1,758,058 |

| Year 3 (10/1/2013 – 9/30/2014) | Milestone 4 [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services  
Metric 1 [I-6.2]: percent of patients without a primary care provider (PCP) who received education about a primary care provider (PCP) who received education about a primary care provider in the ED  
Goal: Currently, there is no process in place to systematically ensure that patients receive information specific to primary care resources in the community. Baseline: 0 patients receiving standardized educational materials. We hope to increase the number of patients receiving education to 1,000 by DY4.  
Milestone 4 Estimated Incentive Payment: $1,763,168 |
| Milestone 4 Estimated Incentive Payment: $1,763,168 |
| Milestone 5 [P-8]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around similar projects.  
Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP  
Baseline/Goal: West Houston hopes to share ideas with other providers |
| Milestone 5 Estimated Incentive Payment: $2,913,061 |

| Year 4 (10/1/2014 – 9/30/2015) | Milestone 6 [I-7]: Reduce number of ED visits and/or avoidable hospitalizations for patients enrolled in the navigator program  
Metric 1 [I-7.1]: ED visits and/or avoidable hospitalizations  
Goal: decrease ED visits by geriatric patients enrolled in the navigation program by 7% over baseline  
Data Source: EHR, navigation program database, ED records, inpatient records |
| Milestone 6 Estimated Incentive Payment: $2,913,061 |

| Year 5 (10/1/2015 – 9/30/2016) | Milestone 6 [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services  
Metric 1 [I-6.2]: percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED  
Goal: HCA will increase the number of patients receiving education to 1,500 by DY4.  
Estimated patient impact: 4,150 total patients in the patient navigator program |
<p>| Milestone 6 Estimated Incentive Payment: $2,913,061 |</p>
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated patient impact: 730 patients in the patient navigator program.</td>
<td>Estimated patient impact: 2,075 patients enrolled in the patient navigator program.</td>
<td>Milestone 5 Estimated Incentive Payment: $1,763,168</td>
<td>Milestone 5 Estimated Milestone Bundle Amount: $2,913,061</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data source: Documentation of semi-annual meetings, including agendas, slides, and/or meeting notes</td>
<td></td>
</tr>
</tbody>
</table>
Category III
Baylor College of Medicine
Pass 1
Title of Outcome Measure (Improvement Target): IT-12.6 Other: Reduction of STI Rate among Adolescents and Young Adults

Unique RHP outcome identification number(s): 082006001.3.1
Performing Provider Name/TPI: Baylor College of Medicine/082006001

Outcome Measure Description:
Because this is a new clinic, process milestone P-2 was selected to establish the baseline to which improvement will be compared. Outcome improvement target IT-1.20 was selected; the measure will be reduction in STI (chlamydia, gonorrhea and syphilis) rates by 5% compared to the baseline in DY5.

Process Milestones:
- DY3: P-2
- DY2: P-1

Outcome Improvement Target(s):
- DY4: IT-12.6
- DY5: IT-12.6

Rationale:
Because the Baylor Teen Health Clinic (BTHC) focuses on prevention, the proposed Category 3 measure is reduced STI rate. The primary prevention milestones identified on the Category 3 do not address the salient health issues faced by adolescents and young adults. Because STIs disproportionately affect this population, the STI rate is a more appropriate metric that clearly measures the success of the STI counseling proposed in the Category 1 improvement measures. Because the goal is to reduce the rate among the population served by the BTHC, baseline data will be established during the first full year the clinic is operational (DY3). The mission of the BTHC is to provide access to affordable care for at-risk, underserved teens in the community. By reducing STI rates and associated sequelae the BTHC will help its young patients avoid long-term health effects associated with STIs.

Outcome Measure Valuation:
The value of this project was determined by an econometrics assessment of STI treatment. Researchers at the CDC have evaluated the cost effectiveness of STI treatment\(^1\) and developed formulae to assess the direct and indirect cost savings of education, screening and treatment. The formula developed for HIV costs averted by HIV counseling and testing was used to calculate the estimated bundle amount for STI counseling, as HIV counseling is included in all STI education, and screening is available to all patients. The estimated bundle amount for STI treatment was based on the pro rata sequelae costs averted for the treatment of gonorrhea, which is a more conservative estimate than that for treatment of chlamydia or syphilis, and it is estimated that 90% of patients treated will be women. The value for decreases in STI rates is based on treatment and pro rata sequelae costs averted because of reductions in the infections in the population, assuming the reductions occur in a patient population of 1,000 patients, or 10 cases avoided per percentage point reduction.

---

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>082006001.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><em>To be established in DY3</em></td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt; (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt; (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-1]: Complete project plan.</strong>&lt;br&gt; Data Source: Project plan document.</td>
<td><strong>Process Milestone 2 [P-2]: Establish STI rate baseline.</strong>&lt;br&gt; Data Source: Health Record</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 2,950</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 6,400</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 2,950</td>
<td>Year 3 Estimated Outcome Amount: $ 6,400</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $ 34,550*
**Title of Outcome Measure (Improvement Target):** IT-12.6 Other: Reduction of Pregnancy Rates among Adolescents and Young Adults

**Unique RHP outcome identification number:** 082006001.3.2

**Performing Provider Name/TPI:** Baylor College of Medicine/082006001

**Outcome Measure Description:**
Because this is a new clinic, process milestone P-2 was selected in order to establish the baseline to which we can compare outcomes. Outcome IT-1.20 was selected to measure reduction in pregnancy rates by 2% compared to the baseline in DY5.

**Process Milestones:**
- DY2: P-1
- DY3: P-2

**Outcome Improvement Target(s):**
- DY4: IT-12.6
- DY5: IT-12.6

**Rationale:**
Because the BTHC focuses on prevention, the proposed Category 3 measure is reduced pregnancy rates. Pregnancy reduction is an appropriate measure for this population. The chronic disease milestones identified in Category 3 pertain to improvements in low birth weight, infant mortality, etc., which do not apply if pregnancy is avoided altogether. The primary prevention milestones also do not address the salient health issues of adolescents and young adults. Decreasing teen pregnancies and births will indicate that the BTHC succeeds in providing access to family planning and contraception services. Because the goal is to reduce the rate among the population served by the BTHC, baseline data will be established during the first full year the clinic is operational (DY3). The mission of the BTHC is to provide access to affordable care for at-risk, underserved teens in the community. By reducing teen pregnancy, the BTHC will help its young patients become contributing members of society.

Based on our experience at other Baylor Teen Health Clinics, reducing pregnancy rates takes time as we make the existing population aware of available services. Moving into a new population or geographic area means that we must ramp up our communications efforts. In the first years, pregnant patients come to our clinics to take advantage of prenatal and parenting services. They then use our services to avoid a second unplanned pregnancy. It typically takes up to five years achieve a 5% reduction in pregnancy rates. The speed of reduction increases as the population becomes more aware of our services and takes advantage of them.

**Outcome Measure Valuation:**
The value of this project was determined by an econometrics assessment of teen pregnancy. The National Campaign determined that the average cost to taxpayers for teen births between 1991
and 2004 was $15.1 billion\(^2\), or an average of $20,000 per birth. This cost includes medical expenses, welfare services and productivity loss. The costs averted are broken further into episodic costs of $5,000 for the cost of delivery and healthcare for mother and child the first year after birth. The remaining $15,000 is prorated for the life of the Waiver. Based on the average birth rate for Harris County, successful family planning will help us avoid an additional 63 births per 1,000 patients. Teen pregnancy rates in the neighborhoods currently serviced by the Teen Clinic are higher than the Harris County average. By reducing the pregnancy rate, we will achieve additional savings in healthcare costs and taxpayer burden that are not duplicated in the estimated bundle for the rendering of contraception management services.

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>082006001.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be established in DY3</td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
</tr>
</tbody>
</table>
| **Process Milestone 1 [P-1]:** Project panning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans | **Process Milestone 2 [P-2]:** Establish baseline pregnancy rate.  
Data Source: Health Record  
Process Milestone 2 Estimated Incentive Payment: $48,000 | **Outcome Improvement Target 1 [IT-12.6]:** Reduce pregnancy rate.  
Improvement Target: Reduce pregnancy rate by 1% over baseline.  
Data Source: Health Record  
Outcome Improvement Target 1 Estimated Incentive Payment: $77,250 | **Outcome Improvement Target 2 [IT-12.6]:** Reduce pregnancy rate.  
Improvement Target: Reduce pregnancy rate by 2% over baseline.  
Data Source: Health Record  
Outcome Improvement Target 2 Estimated Incentive Payment: $111,750 |
| Year 2 Estimated Outcome Amount: $21,800 | Year 3 Estimated Outcome Amount: $48,000 | Year 4 Estimated Outcome Amount: $77,250 | Year 5 Estimated Outcome Amount: $111,750 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $258,800
**Title of Outcome Measure (Improvement Target):** IT-1.10 Improved HbA1c Control

**Unique RHP outcome identification number(s):** 082006001.3.3

**Performing Provider Name/TPI:** Baylor College of Medicine/082006001

**Outcome Measure Description:** Because this is a new clinic, process milestone P-2 was selected in order to establish the baseline to which we can compare outcomes. Outcome IT-1.10 was selected to measure improvement in Diabetes care control by 15% in DY5 compared to the baseline.

**Process Milestones:**
- DY2: P-1
- DY3: P-2

**Outcome Improvement Target(s):**
- DY4 and DY5: IT-1.10 Improve Hb1Ac control showing increased improvement year over year

**Rationale:** The Fifth Ward has been identified as a medically underserved area and is predominantly comprised of residents who identify themselves as Black, Hispanic or Latino. Improvements in HbA1c control can improve patient quality of life and cost of care by reducing the lifetime incidence of blindness, end-stage renal disease (ESRD) and coronary artery disease. Black and Hispanic patients have higher rates of diabetes and higher mortality rates due to diabetes than white patients. African Americans are more likely to develop ESRD. This measure will reflect the Fifth Ward Clinic’s success in implementing continuous process improvements to improve patient outcomes.

**Outcome Measure Valuation:** The value of weight reduction was calculated based on the percentage of the population that is obese and not currently diagnosed with diabetes. Of those patients, it is expected that a 5-7% reduction in weight will reduce the risk of diabetes by 58%. The annual savings was applied to the number of diabetes cases avoided due to weight management for the duration of the Waiver.

---


<table>
<thead>
<tr>
<th>082006001.3.3</th>
<th>3.IT-1.10</th>
<th>Improved HbA1c Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baylor College of Medicine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong></td>
<td><strong>Process Milestone 2 [P-2]:</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
</tr>
<tr>
<td>Complete project plan.</td>
<td>Establish baseline percentage of patients with poor HbA1c control (&gt;9.0%).</td>
<td>Improve HbA1c control Improvement Target: 10% improvement over baseline.</td>
<td>Improve HbA1c control Improvement Target: 15% improvement over baseline.</td>
</tr>
<tr>
<td>Data Source: Project plan document.</td>
<td>Data Source: EHR</td>
<td>Data Source: EHR</td>
<td>Data Source: EHR</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $46,000</td>
<td>Process Milestone 2 Estimated Incentive Payment: $100,000</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $163,300</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $234,000</td>
</tr>
</tbody>
</table>

**Starting Point/Baseline:**

- To be established in DY 3

**Data Source:**

- Project plan document.
- EHR

**Process Milestone 1 Estimated Incentive Payment:** $46,000

**Process Milestone 2 Estimated Incentive Payment:** $100,000

**Outcome Improvement Target 1 Estimated Incentive Payment:** $163,300

**Outcome Improvement Target 2 Estimated Incentive Payment:** $234,000

**Year 2 Estimated Outcome Amount:** $46,000

**Year 3 Estimated Outcome Amount:** $100,000

**Year 4 Estimated Outcome Amount:** $163,300

**Year 5 Estimated Outcome Amount:** $234,000

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**

(Add outcome amounts over DYs 2-5): $543,300
Title of Outcome Measure (Improvement Target): IT-1.20 Improved Weight Control

Unique RHP outcome identification number(s): 082006001.3.4
Performing Provider Name/TPI: Baylor College of Medicine/082006001

Outcome Measure Description:
Because this is a new clinic, process milestone P-2 was selected in order to establish the baseline population. Outcome IT-1.20 other outcome improvement target was selected to measure weight loss of at least 5% in 10% of the target population by DY5.

Process Milestones:
- DY2: P-1
- DY3: P-2

Outcome Improvement Target(s) for each year:
- DY4 and DY5: IT-1.20 Improve weight control showing increased improvement year over year

Rationale:
The Fifth Ward has been identified as a medically underserved area\(^7\) and is predominantly comprised of residents who identify themselves as Black, Hispanic or Latino\(^8\). Weight management is a proposed outcome measure under option IT-1.20. According to the Health of Houston Survey in 2010, 32% of Houston area adults were obese, compared to 29% across the State of Texas\(^5\) with a high prevalence among non-Hispanic blacks (51% higher) and Hispanics (21% higher)\(^10\). Obese patients face a higher risk of developing diabetes\(^11\), and weight loss can significantly reduce that risk\(^12\). Helping patients achieve healthier weights can reduce mortality and morbidity and their attendant costs associated with diabetes as well as, creating an overall healthier population with decreased risk of other medical complications.

Outcome Measure Valuation:
The value of weight reduction was calculated based on the percentage of the population that is obese\(^18\) and not currently diagnosed with diabetes\(^20\). Of those patients, it is expected that a 5-7% reduction in weight will reduce the risk of diabetes by 58\(^21\). The annual savings\(^21\) was applied to the number of diabetes cases avoided due to weight management for the duration of the Waiver.

---

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Improved Weight Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>082006001.2.1</td>
</tr>
</tbody>
</table>

### Baylor College of Medicine

<table>
<thead>
<tr>
<th>Year</th>
<th>Starting Point/Baseline</th>
<th>Process Milestone 1 [P-1]:</th>
<th>Process Milestone 2 [P-2]:</th>
<th>Outcome Improvement Target 1 [IT-1.20]:</th>
<th>Outcome Improvement Target 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>(10/1/2012 – 9/30/2013)</td>
<td>Complete project plan.</td>
<td>Establish baseline number of obese patients (BMI ≥ 30). Data Source: EHR</td>
<td>Improve weight control (loss of ≥ 5% of body weight). Improvement Target: Improved control in 5% of target population. Data Source: EHR</td>
<td>Improve weight control (loss of ≥ 5% of body weight). Improvement Target: Improved control in 10% of target population. Data Source: EHR</td>
</tr>
<tr>
<td>3</td>
<td>(10/1/2013 – 9/30/2014)</td>
<td>Process Milestone 1 Estimated Incentive Payment: $11,800</td>
<td>Process Milestone 2 Estimated Incentive Payment: $25,700</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $42,000</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $60,300</td>
</tr>
<tr>
<td>4</td>
<td>(10/1/2014 – 9/30/2015)</td>
<td>Year 2 Estimated Outcome Amount: $11,800</td>
<td>Year 3 Estimated Outcome Amount: $25,700</td>
<td>Year 4 Estimated Outcome Amount: $42,000</td>
<td>Year 5 Estimated Outcome Amount: $60,300</td>
</tr>
<tr>
<td>5</td>
<td>(10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $139,800

---

**Data Source:**
- Project plan document.
- EHR.
**Title of Outcome Measure (Improvement Target):** IT-12.2 Improved Cervical Cancer Screening

**Unique RHP outcome identification number(s):** 082006001.3.5

**Performing Provider Name/TPI:** Baylor College of Medicine/082006001

**Outcome Measure Description:** Because this is a new clinic, process milestone P-2 was selected in order to establish the baseline to which we can compare outcomes. Outcome IT-12.2 was selected to improve cervical cancer screening rates by 10% over the baseline by DY5.

**Process Milestones:**
- DY2: P-1
- DY3: P-2

**Outcome Improvement Target(s):**
- DY4 and DY5: IT-12.2 Increase cervical cancer screening showing improvement year over year

**Rationale:** The clinic’s goals include ensuring access to timely preventative care. Improvement in cervical cancer screening was selected from this outcome domain in order to measure the clinic’s success in achieving this goal. It is complimentary to the other outcome measures as an additional screening and preventative measure ensuring that the health and well being of this target population is maintained.

Improvements in cervical cancer screening can reduce the incidence of cervical cancer by as much as 93%, while also decreasing associated mortality and lowering treatment costs\(^\text{13}\). Black and Hispanic women have much higher rates of incidence and mortality when compared to the general population,\(^\text{14}\) of which is a large percentage of this target population\(^\text{15}\).

**Outcome Measure Valuation:** The value of cervical screening was based on the differential costs of treating localized lesions and cancers and treating regional and distant cancers\(^\text{16}\). The initial, interim and pro rata final stage costs are calculated based on the current incidence of cancer rates in Texas\(^\text{17}\) and the reduction of invasive rates when screening occurs every two years.

---


### Improved Cervical Cancer Screening

**Starting Point/Baseline:**
- **Year 2** (10/1/2012 – 9/30/2013): Process Milestone 1 [P-1]: Complete project plan.
  - Data Source: Project plan document.
  - Process Milestone 1 Estimated Incentive Payment: $7,200
- **Year 3** (10/1/2013 – 9/30/2014): Process Milestone 2 [P-2]: Establish baseline percentage of women who received a PAP within the past two years.
  - Data Source: EHR
  - Process Milestone 2 Estimated Incentive Payment: $16,000
- **Year 4** (10/1/2014 – 9/30/2015): Outcome Improvement Target 1 [IT-12.2]: Improve percentage of women who received a PAP within the past two years, 5% improvement over baseline.
  - Data Source: EHR
  - Outcome Improvement Target 1 Estimated Incentive Payment: $25,700
- **Year 5** (10/1/2015 – 9/30/2016): Outcome Improvement Target 2 [IT-12.2]: Improve percentage of women who received a PAP within the past two years, 10% improvement over baseline.
  - Data Source: EHR
  - Outcome Improvement Target 2 Estimated Incentive Payment: $36,700

#### Yearly Estimated Outcome Amounts:
- **Year 2** Estimated Outcome Amount: $7,200
- **Year 3** Estimated Outcome Amount: $16,000
- **Year 4** Estimated Outcome Amount: $25,700
- **Year 5** Estimated Outcome Amount: $36,700

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $85,600
Title of Outcome Measure (Improvement Target): IT-12.6 Other: Increase in HPV Vaccinations among Adolescents and Young Adults.

Unique RHP outcome identification number(s): 082006001.3.6
Performing Provider Name/TPI: Baylor College of Medicine/082006001

Outcome Measure Description:
Because this is a new clinic, process milestone P-2 was selected to establish the baseline to which improvement will be compared. Outcome improvement target IT-12.6 was selected; the measure will be increase in age-appropriate immunization rates by 10% compared to the baseline in DY5.

Process Milestones:  
- DY3: P-2  
- DY2: P-1

Outcome Improvement Target(s):  
- DY4: IT-12.6  
- DY5: IT-12.6

Rationale:
Because the Baylor Teen Health Clinic (BTHC) focuses on prevention, the proposed Category 3 measure is increased vaccinations for HPV. The primary prevention milestones identified on the Category 3 protocol do not address the salient health issues faced by adolescents and young adults. Although the BTHC provides catch-up immunizations for common infectious diseases for patients who need them, HPV was selected because it is usually given in this age group and provides protection against the most common STI among youth. At nearly 7 million new infections diagnosed annually\(^\text{18}\), the majority of cases are high-risk HPV strains\(^\text{19}\). The CDC estimates that 21,000 cancer cases annually could be prevented by HPV vaccines\(^\text{20}\). Providing HPV vaccinations to both young men and women can reduce HPV transmission rates and prevent some types of HPV-related cancers, thereby reducing overall healthcare costs associated with HPV.

Outcome Measure Valuation:
The value of HPV vaccinations was based on the cost of cervical cancer treatment only and assumes that 30% of cases would not otherwise be prevented. After considering the local rates of cervical cancer, the value of HPV vaccinations was based on the costs of treating localized lesions as well as regional and distant cancers\(^\text{21}\). The initial, interim and pro rata final stage costs are calculated based on the current incidence of cancer rates in Texas\(^\text{22}\).

---


### Increase in HPV Vaccinations among Adolescents and Young Adults

**Baylor College of Medicine**

**Related Category 1 or 2 Projects:**

**Starting Point/Baseline:**  
To be established in DY3

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1 [P-1]:** Complete project plan.  
Data Source: Project plan document.  
Process Milestone 1 Estimated Incentive Payment: $4,405

**Process Milestone 2 [P-2]:** Establish immunization administration baseline.  
Data Source: Health Record  
Process Milestone 2 Estimated Incentive Payment: $9,600

**Outcome Improvement Target 1 [IT-12.6]:** Increase immunizations.  
Improvement Target: Increase number of immunizations by 5% compared to baseline.  
Data Source: Health Record  
Outcome Improvement Target 1 Estimated Incentive Payment: $15,450

**Process Milestone 2:** Establish immunization administration baseline.  
Data Source: Health Record

**Outcome Improvement Target 2 [IT-12.6]:** Increase immunization rate.  
Improvement Target: Increase number of immunizations by 10% compared to baseline.  
Data Source: Health Record  
Outcome Improvement Target 2 Estimated Incentive Payment: $22,350

**Year 2 Estimated Outcome Amount:** $4,405  
**Year 3 Estimated Outcome Amount:** $9,600  
**Year 4 Estimated Outcome Amount:** $15,450  
**Year 5 Estimated Outcome Amount:** $22,350

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**

*(add outcome amounts over DYs 2-5): $51,800*
Bayshore Medical Center
Pass 1
**Title of Outcome Measure (Improvement Target):** Category 3: Quality Improvements: Outcome Domain 8: Perinatal Outcomes Improvement Target 8.2: Percentage of Low Birth Weight births

**Performing Provider Name/TPI:** HCA Bayshore Medical Center/020817501

**Unique RHP outcome identification number(s):** 020817501.3.1

**Outcome Measure Description:**
Bayshore will reduce the number of infants born to mothers seen at its three local OB/GYN clinics with low birth weight, defined as infants weighing less than 2500 grams at birth. Bayshore will achieve this outcome by providing earlier and more consistent care to expectant mothers, and increased education about maintaining a health pregnancy, which will improve the health outcomes of these pregnancies (both for the infants and the mothers). Healthily maintained pregnancies are more likely to produce full-term babies, and also to produce developmentally on-target infants, both of which should cause higher, healthier birth weights than may have otherwise resulted.

**Process Milestones:**
HCA chose its DY 2-3 process milestones in order to establish a baseline rate of low birth weights for infants born to mothers treated at Bayshore’s clinics (by which to measure progress going forward), and to develop a plan for making sure that the expanded OB/GYN capacity translates into improved health for newborns, including a healthy birth weight.

**Rationale:**
HCA selected this outcome because low birth weight is associated with myriad of immediate and long-term health problems, including feeding issues, inhibited growth, cognitive and developmental delays, and chronic diseases later in life. Harris County newborns suffer from a higher rate of low-birth weight than the statewide average, making this an important outcome for Bayshore’s community. Factors related to the expectant mother that can result in low-birth weight include smoking, drinking alcohol, diabetes, heart disease, poor nutrition, and stress. Increased access to OB/GYN services will allow mothers at risk for infants with low-birth weight to receive the education, support, and skills necessary to address these factors before or during pregnancy, thereby reducing the likelihood of giving birth to a child under 2500 gram in weight. Additionally, the cost of treating newborns with low birth weight is hard to measure, as it can lead to so many other health problems in the near and distant future. Needless to say, the systemic cost savings associated with preventing low birth weight would have a meaningful impact on the delivery system and allow for reinvestment of funds into much-needed primary and preventative care.

**Outcome Improvement Targets for each year:**
During DY2, HCA will determine the percentage rate of improvement it will target in DYs 4-5. Upon determining the baseline and creating a plan for improving patient education, awareness, and health during pregnancy, Bayshore will determine in DY3 reasonable, yet impactful, percentages of improvement to target.
**Outcome Measure Valuation:**
The valuation of each HCA Bayshore Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. The value of this outcome incorporates the potential health benefits for infants born at a healthy weight, the increased satisfaction for the mothers and families of the healthy infants, and the immediate and long-term cost savings associated with providing health care to these infants as they mature.
**Perinatal Outcomes: Percentage of Low birth weight births**

**HCA – Bayshore**

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>020817501.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1**

**P-2**: Establish a baseline – HCA will measure the number of low birth weight births to women treated at its three local clinics.

*Data Source: Hospital data reports*

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $424,794

**Process Milestone 2**

**P-1**: Project planning – develop a plan for using the expanded OB/GYN capacity to reach more expectant mothers and provide the education, support, and interventions they need to maintain healthy, full-term pregnancies, resulting in a reduced rate of low birth weight (including community outreach, classes, and/or patient protocols)

*Data Source: Program materials.*

**Process Milestone 2 Estimated Incentive Payment:** $492,392

**Outcome Improvement Target 1**

**IT 8.2**

**Improvement Target:** Decrease the number of low birth weight births to mothers treated at Bayshore’s three local clinics by X% under baseline (TBD)

*Data Source: Hospital admission records*

**Outcome Improvement Target 1 Estimated Incentive Payment:** $790,117

**Outcome Improvement Target 2**

**IT-8.2**

**Improvement Target:** Decrease the number of low birth weight births to mothers treated at Bayshore’s three local clinics by X% under baseline (TBD)

*Data Source: Loan documentation*

**Outcome Improvement Target 2 Estimated Incentive Payment:** $1,889,411

**Year 2 Estimated Outcome Amount:** $424,794

**Year 3 Estimated Outcome Amount:** $492,392

**Year 4 Estimated Outcome Amount:** $790,117

**Year 5 Estimated Outcome Amount:** $1,889,411

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $3,596,714
**Title of Outcome Measure (Improvement Target):**

Outcome Domain 3: Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs)
Improvement Target: 3.8: Behavioral Health / Substance Abuse 30 day readmission rate

**Unique RHP outcome identification number(s):** 020817501.3.2

**Performing Provider/TPI:** Bayshore Medical Center/20817501.

**Outcome Measure Description:**
HCA chose this outcome because one expected outcome of the implementation of tele-psychiatry services at Bayshore and other HCA hospitals in the area is an improvement in the clinical indicators for BH/SA patients. Reduced wait times in the ED for treatment and/or referral to the appropriate care setting is the clinical indicator that Bayshore will measure, as this aspect of the patient’s experience in the health care system is tied to improved patient outcomes and reduction in the BH/SA readmission rate.

**Process Milestones:**
Bayshore chose its DY2 milestone in order to establish the average wait times experienced by BH/SA patients (as a primary or secondary diagnosis) in the EDs at the hospitals participating in the tele-psychiatry program. Bayshore will use this number as a baseline by which to measure improvement going forward.

**Outcome Improvement Target(s) for each year:**
During DYs 3-5, Bayshore will measure the BH/SA readmission rate against the baseline set in DY3, with a 10% improvement in DY4, and a 15% improvement over DY3 in DY5.

**Rationale:**
Bayshore selected this project for several reasons. First, most of Houston is comprised of federally-designated Health Provider Shortage Areas (including Harris County Hospital District, and many geographical areas within and around Houston) in the domain of mental health. The shortage of providers results in a disparity in the access to primary, preventative, and specialty care for residents requiring BH/SA health care. As a result of this issue, many patients present at East Houston, West Houston, or Woman’s Hospital for BH/SA treatment, and languish in the ED for hours or even days because they simply do not have the capabilities to properly assess their conditions, provide treatment, or refer these patients to the appropriate setting. At Bayshore, there are limited provider resources to treat these patients (being the only hospital in this network with psychiatric beds), meaning that the patients also spend more time than they should in the ED, which takes beds from emergent patients.

By increasing access to these much needed psychiatric services, and providing a more efficient assessment via tele-psychiatry, patients will receive the care they need in a more timely manner. This increased access to services will improve health outcomes by assessing the patient more quickly, which will allow treatment to begin more quickly. This outcome measure will focus on reducing the readmission of this target population, which will be a savings to the overall healthcare delivery system, as the average cost on a BH inpatient stay at Bayshore is $3,723.00. Inpatient stays have a negative impact on patient short-term health outcomes, and reduce patient satisfaction and quality of life. For
each of these reasons, Bayshore will use the BH/SA readmission rate as a clinical indicator of improvement for this group identified as traditionally underserved by the healthcare system.

**Outcome Measure Valuation:**
The valuation of each HCA Bayshore Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. The value of this outcome lies in the potential for improvement to BH/SA patient outcomes and satisfaction, as well as reducing the incidence of readmission of this population by providing more efficient and timely assessment of each patient.
<table>
<thead>
<tr>
<th>Process Milestone 1</th>
<th>Outcome Improvement Target 1</th>
<th>Outcome Improvement Target 2</th>
<th>Outcome Improvement Target 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>[P-2]: Establish a baseline – HCA will measure the number of PPRs for BH/SA related conditions during DY2, in order to measure progress going forward</td>
<td>IT-3.8]: Behavioral Health/Substance Abuse (BH/SA) readmission rate. Improvement Target: 5% improvement over baseline set in DY2. Data Source: EHR; claims.</td>
<td>IT-3.8]: Behavioral Health/Substance Abuse (BH/SA) readmission rate. Improvement Target: 10% improvement over baseline set in DY2. Data Source: EHR; claims.</td>
<td>IT-3.8]: Behavioral Health/Substance Abuse (BH/SA) readmission rate. Improvement Target: 15% improvement over baseline set in DY2. Data Source: EHR; claims.</td>
</tr>
<tr>
<td>Data Source: Hospital data reports</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $533,142</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $855,506</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $2,045,776</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: $459,950</td>
<td>Year 3 Estimated Outcome Amount: $533,142</td>
<td>Year 4 Estimated Outcome Amount: $855,506</td>
<td>Year 5 Estimated Outcome Amount: $2,045,776</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $3,894,374
City of Houston Department of Health and Human Services

Pass 1
Project Option - Project Option 1.8.9 - Expansion of school-based sealant and/or fluoride varnish programs that provide sealant placement and/or fluoride varnish applications to otherwise un-served school-aged children by enhancing dental workforce capacity.

**Unique Project ID:** 0937740-08.1.1

**Performing Provider Name/TPI:** City of Houston Department of Health and Human Services/0937740-08

**Project Summary:** Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

**Intervention(s):** This new project will improve dental health in Medicaid/CHIP or indigent populations by:
1) expanding new diagnostic, preventive, restorative, and surgical oral health services for safety net eligible persons,
2) expanding an evidence-based dental sealant program for elementary school children in low income areas
3) initiating new diagnostic, preventive, restorative, and surgical oral health services for eligible perinatal women through three months post-partum.

**Need for the Project:** The performing provider anticipates treating fewer cases of Early Childhood Caries (ECC) among the child patients (<6 years of age) it serves by expanding an existing program that provides screening, oral health education, sealants, and fluoride varnish for at-risk 2nd graders that are on CHIP/uninsured.

**Target Population:** The primary target population will be at risk 2nd graders that are in schools with a high proportion of minority and low income families. The secondary target group will be eligible perinatal women through post-partum.

**Category 1 or 2 expected patient benefits:** Increase by 5% over baseline the number of special population members that access services in past 12 months in DY4 and increase by 10% over baseline the number of special population members that access services in past 12 months.

a) For Oral Health for At Risk Population in DY3 a baseline of 3515 children will receive dental sealants, to increase to 3690 in DY4 and 3875 in DY5.

b) For Dental Safety Net, to decrease number of children with untreated caries, a baseline of 850 will be established in DY3, 807 in DY4 and 767 in DY5.
c) For Perinatal Oral Health, to increase the number of pregnant women who access oral health services, the unduplicated baseline is 300 in DY3, 315 in DY4 and 331 in DY5. For total number of encounters, a baseline of 900 will be established in DY3, 945 in DY4 and 993 in DY5.

Category 3 outcomes: IT-7.1 Dental Sealant: Increase percentage of children age 6-9 with a dental sealant on a permanent first molar tooth by 5% over baseline in DY4 and by 10% over baseline in DY5 IT-7.2 Cavities: Increase percentage of children with untreated dental caries by 2% over baseline in DY4 and by 5% over baseline in DY5.

Title of Outcome Measure (Improvement Target): IT 7.1- Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Healthy People 2020; CMS Oral Health Initiative goal

Unique RHP Outcome identification number(s): 0937740-08.3.1

Performing Provider: City of Houston Department of Health and Human Services/ 0937740088

Outcome Measure Description:
IT-7.1 Dental Sealant:
   o Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Healthy People 2020; CMS Oral Health Initiative goal

Process Milestones:
   o DY 2
   o Establish Baseline Rates
   o DY3:
   o P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve program
   o P-5: Milestone: Disseminate lessons learned and best practices

Outcome improvement targets for each year:
   • DY 4:
   o IT-7.1 Dental Sealant: Increase by 5% over baseline, Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Healthy People 2020; CMS Oral Health Initiative goal
   • DY 5
   o IT-7.1 Dental Sealant: Increase by 10% over baseline, Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Healthy People 2020; CMS Oral Health Initiative goal (Non-standalone measure)

Rationale:
The Outcome Improvement target for this project was chosen because application of dental sealants in underserved elementary school children promotes dental health in the future. By increasing the percentage of children who receive dental sealants, this program will promote and enhance dental health in underserved children and help close disparities in dental health. The process milestones P4 and P5 were chosen for this project based on the need for documentation of baseline and continuous quality improvements in program for sealant application and dental care. The PDSA cycle will inform systematic data driven program
improvements. Inadequate access to dental services compounds other health issues. It can result in untreated dental disease that not only affects the mouth, but can also have physical, mental, economic and social consequences. Fortunately, many of the adverse effects associated with poor oral health can be prevented with quality regular dental care, both at home and professionally. Increasing, expanding, and enhancing dental services will improve overall health outcomes. The improvement targets are based on the two single most important indicators for childhood dental health. Children who have regular access to a dental provider are more likely to have received dental services that can prevent or treat early dental disease. Additionally, unserved or underserved perinatal women are a specially vulnerable group not only for their own dental health but also for the dental health of their children. Education on the importance of dental health can help promote better dental health in young children.

**Outcome Measure Valuation:**

The Outcome measure was valued at 12.29% of the overall assigned project value for the associated Category 2 project in year 3, 12.29% in Year 4 and 12.29 % in Year 5. HDHHS utilized the following method to determine the Category 2 project value. HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4) Cost Avoidance 5) Partnership Collaboration and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a predetermined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or reoccurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. Oral Health Service Expansion received a composite Prioritization score of 7.65 and a Public Health Impact score of 7.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1 [P-2]** Establish baseline rates

**Metric 1:** Calculate baseline rate of dental sealants in children age 6-9 in the Oral Health Program in DY2, months 6-12.

**Goals:** Establish baseline against which improvements can be measured.

**Data Sources:** Program documentation from month 6-12 in DY2.

**Numerator:** # of children age 6-9 years with dental sealant enrolled in the Oral Health Program.

**Denominator:** Total # of children of same age enrolled in the program.

**Milestone 1 Estimated Incentive Payment:** $62,267.21

**Process Milestone 2 [P-4]:** Conduct Plan Do Study Act cycle to continually improve

**Metric 1:** Document use of PDSA in planning process

- Goal: Goal: Ensure highest quality on program process and improvement.

- **Data Source:** Step-wise documentation of PDSA in program documentation.

**Milestone 2 Estimated Incentive Payment:** $72,845.65

**Process Milestone 3 [P-5]:** Disseminate lessons learned and best practices

**Metric 1:** Documentation of best practices


- **Data Source:** Documentation of report.

**Milestone 3 Estimated Incentive Payment:**

**Outcome Improvement Target 1 [IT-7.1]:** Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Healthy People 2020; CMS Oral Health Initiative goal).

- **Improvement Target:** Increase rate of dental sealant in children by 5% over baseline (Baseline will be determined in DY2).

- **Data Source:** Program Electronic Records.

**Numerator:** Number of children age 6-9 with a dental sealant on at least one permanent first molar within the measurement period (past 12 months) enrolled in Program.

**Denominator:** Total number of children age 6-9 that have seen a dental provider within the measurement period (past 12 months) enrolled in Program.

**Outcome Improvement Target 1 Estimated Incentive Payment:** $155,094.92

**Outcome Improvement Target 2 [IT-7.1]:** Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Healthy People 2020; CMS Oral Health Initiative goal).

- **Improvement Target:** Increase rate of dental sealant in children by 10% over Baseline.

- **Data Source:** Program Electronic Records.

**Numerator:** Number of children age 6-9 with a dental sealant on at least one permanent first molar within the measurement period (past 12 months) enrolled in Program.

**Denominator:** Total number of children age 6-9 that have seen a dental provider within the measurement period (past 12 months) enrolled in Program.

**Outcome Improvement Target 2 Estimated Incentive Payment:** $337,243
### Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>0937740-08.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Project Baseline will be established in DY 2</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td></td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td></td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td></td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td>Payment: $72,845.65</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td>$62,267.21</td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount:</td>
<td>$145,691.30</td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount:</td>
<td>$155,094.92</td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount:</td>
<td>$337,243</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $5,700,296.43
Project Option - Project Option 1.8.9 - Expansion of school-based sealant and/or fluoride varnish programs that provide sealant placement and/or fluoride varnish applications to otherwise un-served school-aged children by enhancing dental workforce capacity.

**Unique Project ID:** 0937740-08.1.1

**Performing Provider Name/TPI:** City of Houston Department of Health and Human Services/0937740-08

**Project Summary:** Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

**Intervention(s):** This new project will improve dental health in Medicaid/CHIP or indigent populations by: 1) expanding new diagnostic, preventive, restorative, and surgical oral health services for safety net eligible persons, 2) expanding an evidence-based dental sealant program for elementary school children in low income areas 3) initiating new diagnostic, preventive, restorative, and surgical oral health services for eligible perinatal women through three months post-partum.

**Need for the Project:** The performing provider anticipates treating fewer cases of Early Childhood Caries (ECC) among the child patients (<6 years of age) it serves by expanding an existing program that provides screening, oral health education, sealants, and fluoride varnish for at-risk 2nd graders that are on CHIP/uninsured.

**Target Population:** The primary target population will be at risk 2nd graders that are in schools with a high proportion of minority and low income families. The secondary target group will be eligible perinatal women through post-partum.

**Category 1 or 2 expected patient benefits:** Increase by 5% over baseline the number of special population members that access services in past 12 months in DY4 and increase by 10% over baseline the number of special population members that access services in past 12 months.

- a) For Oral Health for At Risk Population in DY3 a baseline of 3515 children will receive dental sealants, to increase to 3690 in DY4 and 3875 in DY5.
- b) For Dental Safety Net, to decrease number of children with untreated caries, a baseline of 850 will be established in DY3, 807 in DY4 and 767 in DY5.
c) For Perinatal Oral Health, to increase the number of pregnant women who access oral health services, the unduplicated baseline is 300 in DY3, 315 in DY4 and 331 in DY5. For total number of encounters, a baseline of 900 will be established in DY3, 945 in DY4 and 993 in DY5.

**Category 3 outcomes:** IT-7.1 Dental Sealant: Increase percentage of children age 6-9 with a dental sealant on a permanent first molar tooth by 5% over baseline in DY4 and by 10% over baseline in DY5. IT-7.2 Cavities: Increase percentage of children with untreated dental caries by 2% over baseline in DY4 and by 5% over baseline in DY5.

**Title of Outcome Measure (Improvement Target):** IT-7.2 Cavities: Percentage of children with untreated dental caries (Healthy People 2020)

**Unique RHP Outcome identification number(s):** 0937740-08.3.2

**Performing Provider:** City of Houston Department of Health and Human Services/ 0937740088

**Outcome Measure Description:**
IT-7.2 Cavities: Percentage of children with untreated dental caries (Healthy People 2020) (Standalone measure)

**Process Milestones:**
- **DY 2**
  - Develop and test data systems
- **DY3:**
  - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve program
  - P-5: Milestone: Disseminate lessons learned and best practices

**Outcome improvement targets for each year:**
- **DY 4:**
  - IT-7.2 Cavities: Reduce by 2% over baseline Percentage of children with untreated dental caries (Healthy People 2020) (Standalone measure)
- **DY 5**
  - IT-7.2 Cavities: Reduce by 5% over baseline Percentage of children with untreated dental caries (Healthy People 2020) (Standalone measure)

**Rationale:**
The process milestones P4 and P5 were chosen for this project based on the need for documentation of baseline and continuous quality improvements in program for reduction of dental caries. The PDSA cycle will inform systematic data driven program improvements. Inadequate access to dental services compounds other health issues. It can result in untreated dental disease that not only affects the mouth, but can also have physical, mental, economic and social consequences. Fortunately, many of the adverse effects associated with poor oral health can be prevented with quality regular dental care, both at home and professionally. Increasing, expanding, and enhancing dental services will improve overall health outcomes. The
improvement targets are based on the two single most important indicators for childhood dental health. Children who have regular access to a dental provider are more likely to have received dental services that can prevent or treat early dental disease. Additionally, unserved or underserved perinatal women are a specially vulnerable group not only for their own dental health but also for the dental health of their children. Education on the importance of dental health can help promote better dental health in young children.

**Outcome Measure Valuation:**

The Outcome measure was valued at 12.29% of the overall assigned project value for the associated Category 2 project in year 3, 12.29% in Year 4 and 12.29% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HHDHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HHDHS Valuation Tool). HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4) Cost Avoidance 5) Partnership Collaboration and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HHDHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HHDHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. Oral Health Service Expansion received a composite Prioritization score of 7.65 and a Public Health Impact score of 7.
Goal: Utilize a systematic cyclical process for quality improvement Data Source: Program documentation Milestone 2 Estimated Incentive Payment: $72,845.65 Process Milestone 3 [P-5]: Disseminate lessons learned and best practices Metric 1: Documentation of best practices and lessons learned  
Goal: Share lessons learned to add to knowledge base and inform others implementing similar projects Data Source: Program Documentation Milestone 3 Estimated Incentive Payment: $72,845.65 | Outcome Improvement Target 1 [IT-7.2]: Cavities: Percentage of children with untreated dental caries (Healthy People 2020)  
Goal: Reduce by 2% over baseline the percentage of children with dental caries in the Oral Health program. (Baseline TBD in DY 2-3) Data Source: Program Electronic Records Numerator: Number of children with untreated dental caries (past 12 months) enrolled in Program Denominator: Total number of children that have seen a dental provider within the measurement period (past 12 months) enrolled in Program Outcome Improvement Target 1 Estimated Incentive Payment: $155,094.92 | Outcome Improvement Target 2 [IT-7.2]: Cavities: Percentage of children with untreated dental caries (Healthy People 2020)  
Goal: Reduce by 5% over baseline the percentage of children with dental caries in the Oral Health program Data Source: Program Electronic Records Numerator: Number of children with untreated dental caries (past 12 months) enrolled in Program Denominator: Total number of children that have seen a dental provider within the measurement period (past 12 months) enrolled in Program Outcome Improvement Target 2 Estimated Incentive Payment: $337,243 |
<table>
<thead>
<tr>
<th>ID</th>
<th>Category</th>
<th>Description</th>
<th>Related Category 1 or 2 Projects:</th>
<th>Starting Point/Baseline:</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
<th>Year 2 Estimated Outcome Amount: $62,267.21</th>
<th>Year 3 Estimated Outcome Amount: $145,691.30</th>
<th>Year 4 Estimated Outcome Amount: $155,094.92</th>
<th>Year 5 Estimated Outcome Amount: $337,243</th>
</tr>
</thead>
<tbody>
<tr>
<td>0937740-08.3.2</td>
<td>IT-7.2</td>
<td>Cavities: Percentage of children with untreated dental caries (Healthy People 2020)</td>
<td>[RHP Performing Provider involved with this project - Name] City of Houston Health and Human Services</td>
<td>TBD in DY2-3</td>
<td>Year 2 Estimated Outcome Amount: $62,267.21</td>
<td>Year 3 Estimated Outcome Amount: $145,691.30</td>
<td>Year 4 Estimated Outcome Amount: $155,094.92</td>
<td>Year 5 Estimated Outcome Amount: $337,243</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $700,296.43
Project Option 1.7.7 - Implement remote patient monitoring programs for diagnosis and/or management of care for EMS services.

Unique Project ID: 0937740-08.1.2

Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Summary: Provider: The primary performing provider, City of Houston Fire Department Emergency Medical Services (EMS) is the primary EMS authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. The City of Houston is a six-hundred plus square mile area spread out over a 1000 square mile region in Southeast Texas. Each year there are over 200,000 EMS incidents involving over 225,000 patients or potential patients. On average, EMS responds to a citizen every 3 minutes. Each EMS response is made by one of 88 City of Houston EMS vehicles. Thirty seven of these are staffed by two paramedics and provide Advanced Life Support (ALS) capabilities. The primary performing provider serves all Houston residents, providing high quality medical care that is not defined solely in terms of life-saving interventions for critically-ill or injured patients. High quality emergency medical care is defined by the decisions made on each and every patient encounter. These services that benefit all Houston residents, and frequently, support those most in need, such as low income mothers and children, the elderly, and Medicaid and minority populations. The telehealth program population is expected to consist of approximately 30% Medicaid enrollees and approximately 20% indigent population.

Intervention(s): The City of Houston proposes to make use of telecommunications technologies and connectivity to triage patients with non-life threatening, mild or moderate illnesses via telemedicine with an emergency physician at the City of Houston EMS base station. This new program intends to address 3780 new patients/year in DY4 and 3960 new patients in DY5 by telehealth technology by providing access to the Emergency Telehealth and Navigation (ETHAN) program.

Need for the Project: Rising costs of treating patients with non-emergent conditions that access health care at the ER are well documented. Telehealth provides a viable alternative to direct patients with non-life threatening, mild or moderate illnesses, who would have otherwise been transported to an ED for evaluation.

Target Population: This new program will target callers to 9-1-1 who have been evaluated on site by Houston Fire Department (HFD) - Emergency Medical Technicians (EMT) and/or paramedics, and if appropriate, these callers will be directed to the Emergency Tele Health and Navigation (ETHAN) Program to receive appropriate care at the right setting.

Category 1 or 2 expected patient benefits: Improved access to health care services by 5% over baseline in DY4 and by 10%over baseline in DY 5 for residents of communities that did not have such services locally before the program. A baseline of 300 patients per month will be established during DY3 from the time the program is fully implemented. In DY4 the number of patients seen by ETHAN will increase to 315 per month for a total of 3780 for DY4 and to 330 per month for a total of 3960 for DY5.
Category 3 outcomes: **IT-9.4**: (ED appropriate utilization) - Reduce all ED visits that are non-emergent among 911 callers by 5% over baseline in DY4 and by 10% over baseline in DY5.

**Title of Outcome Measure (Improvement Target):** IT-9.4 Other Outcome Improvement Target (ED appropriate utilization)

**Unique RHP Outcome identification number(s):** 0937740-08.3.3

**Outcome Measure Description:**
IT-9.4 Other Improvement Target (ED appropriate utilization of non-life threatening, mild or moderately ill 911 callers). This program provides care coordination, by more accurately assessing the 9-1-1 caller’s needs via telehealth services and provide the patient more appropriate care in a more appropriate setting than the emergency center. The performing provider and its partners expect to see a reduction in ER usage among non-emergent 911 callers by using telecommunications technologies and connectivity to provide access to underserved non-emergent populations that called 911 through improved access to specialists, improved care satisfaction and reduced emergency room usage.

**Process Milestones:**
- **DY2:**
  - [P-3]: Develop and test Data systems
- **DY 3**
  - P-4 : Conduct and Update Plan-Do-Study-Act for quality improvement
  - P-5 : Disseminate findings, lessons learned and best practices

**Outcome Improvement Targets for each year**
- **DY 4:**
  - IT-9.4 Other Improvement Target (ED appropriate utilization - Stand-alone measure) - Reduce all ED visits that are non-emergent (including ACSC) that call into the 911 system by 5% over baseline.
- **DY 5:**
  - IT-9.4 Other Improvement Target (ED appropriate utilization Stand-alone measure) - Reduce all ED visits that are non-emergent (including ACSC) that call into the 911 system by 10% over baseline.

**Rationale:**
Using telecommunications for patient consults to provide medical data, which may include audio, still or live images, between a patient and a health professional for use in rendering a diagnosis and treatment plan is a viable way to make medical care more accessible. The development and installation of high-speed wireless telecommunications networks coupled with large-scale search engines and mobile devices will change healthcare delivery as well as the scope of healthcare services. It will allow for real-time monitoring and interactions with patients without bringing them into a hospital or a specialty care center. This real/near-time monitoring and interacting could enable a healthcare team to address patient problems before they require major interventions, creating a potentially patient-centered approach that could undoubtedly change our expectations of our healthcare system.
Process measures for Project Planning and implementation needs to happen before lessons learned and best practices can be documented. These measures will be conducted in DY 2 and 3 so that outcomes can be measured in DY 4 and 5.

**Outcome Measure Valuation:**
The Outcome measure was valued at 12.21% of the overall assigned project value for the associated Category 2 project in year 3, 12.21% Year 4 and 12.21% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HHDHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HHDHS Valuation Tool). HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4) Cost Avoidance 5) Partnership Collaboration and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HHDHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HHDHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The Care Houston Links Program received a composite Prioritization score of 7.15 and a Public Health Impact score of 7.

**References:**
1. ER Visits with an ambulance transport. Report from Center for Health Services Research Collaborative. UT School of Public Health, Houston, Texas. Accessed on 10/2/12 from [https://sph.uth.edu/research/centers/chsr/hsrc/](https://sph.uth.edu/research/centers/chsr/hsrc/).
2. Stakeholder input from RHP 3 Working Group Members throughout the Region (including providers, consumers, hospital and clinic administrators, government officials, researchers, and advocacy groups)
4. Dixon BE, Hook JM, McGowan JJ. Using Telehealth to Improve Quality and Safety: Findings from the AHRQ Portfolio (Prepared by the AHRQ National Resource Center
for Health IT under Contract No. 290-04-0016). AHRQ Publication No. 09-0012-EF.
Performing Provider Name: City of Houston Health and Human Services

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>09377740-08.1.2</th>
</tr>
</thead>
</table>

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1 [P-3]:** Develop and test Data systems
- **Metric 1:** Determine and provide documentation of type of system and IT resources needed.
- **Metric 2:** Select, install and test data system
- **Goal:** Install efficient and effective data system to capture program data
- **Data Source:** Documentation of selection, testing and implementation of data system

**Milestone 1 Estimated Incentive Payment:** $123,740.57

**Milestone 2 [P-4]:** Conduct Plan Do Study Act cycle to continually improve
- **Metric 1:** Document use of PDSA in planning process
  - **Goal:** Utilize a systematic cyclical process for quality improvement
  - **Data Source:** Program documentation

**Milestone 2 Estimated Incentive Payment:** $144,762.60

**Milestone 3 [P-5]:** Disseminate lessons learned and best practices
- **Metric 1:** Documentation of best practices and lessons learned
  - **Goal:** Share lessons learned to add to knowledge base and inform others implementing similar projects
  - **Data Source:** Program Documentation

**Milestone 3 Estimated Incentive Payment:** $144,762.60

**Outcome Improvement Target 1 [IT-9.4]:** (ED appropriate utilization) (Stand-alone measure)
- **Improvement Target:** Reduce non-emergent ED visits among 911 callers by 5% over baseline
- **Data Source:** HFD data electronic records
- **Numerator:** Non Emergent mild or moderately ill 911 callers connected to further medical care/follow-up
- **Denominator:** All non-emergent 911 callers

**Outcome Improvement Target 1 Estimated Incentive Payment:** $308,212.55

**Outcome Improvement Target 2 [IT-9.4]:** (ED appropriate utilization) (Stand-alone measure)
- **Improvement Target:** Reduce non-emergent ED visits among 911 callers by 10% over baseline
- **Data Source:** HFD data electronic records
- **Numerator:** Non Emergent mild or moderately ill 911 callers connected to further medical care/follow-up
- **Denominator:** All non-emergent 911 callers

**Outcome Improvement Target 2 Estimated Incentive Payment:** $670,186.51

**Year 2 Estimated Outcome Amount:** $123,740.57
**Year 3 Estimated Outcome Amount:** $289,525.20
**Year 4 Estimated Outcome Amount:** $308,212.55
**Year 5 Estimated Outcome Amount:** $670,186.51

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (*add outcome amounts over DYs 2-5): $1,391,661.83
Project Option - 2.6.3 Engage community health workers in an evidence-based program to increase health literacy of a targeted population.

**Unique Project ID:** 0937740-08.2.1

**Performing Provider Name/TPI:** City of Houston Department of Health and Human Services/0937740-08

**Project Summary:**

Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

**Intervention(s):** This new project proposes to utilize community health workers to provide 24 sessions of essential education and assessment related to fall prevention and safety to 500 low income older adults during the baseline year. Based on other home visitation programs, the population is expected to be 90% being Black or Hispanic. The program will also provide intervention to reduce hazards in the home to 100 of the 500 low income older adults initially recruited into the program.

**Need for the Project:** The risk for a fall increases exponentially with advancing age. Older adults often seek care at the ER for falls related injuries that are preventable. Preventing falls requires a multifactorial approach with assessment and management. This program will provide education, evaluation/assessment and fall-related hazard mitigation at home and follow up by identifying hazards that impair safety and health in the home as part of an evidence-based fall prevention intervention.

**Target Population:** The project will target older adults aged 60 and referrals and recruitment to this program will be generated by home visitation programs of the performing provider or its partners such as Harris County Area Agency on Aging (HCAAA), Houston Department of Health &Human Services (HDHHS)Tuberculosis (TB) Control and other departmental(Communicable Diseases, etc.) and the target population is expected to be 80% Medicaid.

**Category 1 or 2 expected patient benefits:** Increase access to health promotion programs and activities using innovative program by 5% in DY4 from 500 to 525 home safety educations and from 100 to 105 home inspections and by 10% in DY5 to 550 home safety educations and 110 home inspections.
Category 3 outcomes: **IT-9.4**: (ED appropriate utilization) IT-9.4 Milestone: Other Outcome Improvement Target (ED appropriate utilization – Stand-alone measure)

1) Home Safety/ Perception of Home Safety survey to complete while inspecting homes; and of patients who undergo home inspection, do follow-up calls to determine retention.

2) The number of falls among program participants since the inspection.

3) The % of falls, that resulted in 9-1-1 calls and/or ED visits among program participants. Reduce by 5% each the number of ED visits among program participants and number of 911 calls made for falls in older adults 60 years and over from specific zip codes over baseline in DY4 and by 10% over baseline in DY5.

**Title of Outcome Measure (Improvement Target):** IT-9.4 Other Outcome Improvement Target (ED appropriate utilization)

**Unique RHP Outcome Identification Number:** 0937740-08.3.4

**Performing Provider Name/TPI:** City of Houston Department of Health and Human Services / 0937740-08

**Outcome Measure Description:**

IT-9.4 Milestone: Other Outcome Improvement target (ED appropriate utilization (Stand-alone measure))

In 2010, the overall rate of nonfatal fall injury episodes for which a health-care professional was contacted was 43 per 1000 persons. Persons aged > 75 years had the highest rate (115 per 1000 persons) of falls. The primary goal of this program is to prevent fall related accidents that result in Emergency Room (ER) visits. Since the primary recruitment source is the EMS database for 911 calls, this program is expected to reduce 911 calls in targeted high risk zip codes for falls in the home setting. This initiative will implement an Evidence-based Health Promotion Program that utilizes community health workers to increase health literacy, fall prevention intervention and provide minor structural changes in homes of a targeted population. This will be measured based on 3 metrics (listed below).

**Process Milestones:**

- **DY 2**
  - P-3: Develop and test Data systems
- **DY 3**
  - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve program
  - P-5: Milestone: Disseminate lessons learned and best practices

**Outcome Improvement Targets for each year:**

- **DY 4**
  - IT-9.4 Milestone: Other Outcome Measure (ED appropriate utilization)
    - Home Safety/ Perception of Home Safety survey to complete while inspecting homes; and of patients who undergo home inspection, do follow-up calls to determine retention.
    - The number of falls among program participants since the inspection.
The % of falls, that resulted in 9-1-1 calls and/or ED visits among program participants.

- DY 5
  - IT-9.4 Milestone: Other Outcome Measure (ED appropriate utilization)
    - Home Safety/ Perception of Home Safety survey to complete while inspecting homes; and of patients who undergo home inspection, do follow-up calls to determine retention.
    - The number of falls among program participants since the inspection.
    - The % of falls, that resulted in 9-1-1 calls and/or ED visits among program participants.

**Rationale:**
The “Other Outcome Measure” for Category 3 was chosen for this project because it aligns with the goals of the project. Fall related injury and ensuing visit to the ER is one of the 20 most expensive conditions in community dwelling elderly. Preventable falls among community dwelling elderly result in costly morbidity. According to a new CDC study published in the *Morbidity and Mortality Weekly Report (MMWR)*, an estimated 234,000 people ages 15 and older were treated in U.S. emergency departments (ED) in 2008 for injuries that occurred in bathrooms. Four out of 5 of these injuries were caused by falls—which can have especially serious consequences for older adults. Almost one-third (30 percent) of adults aged 65 and above who were injured in bathrooms were diagnosed with fractures. Among adults aged 85 and older, 38 percent were hospitalized as a result of their injuries. Eliminating hazards at home is one of the recommended strategies for fall prevention in older adults. This Fall Prevention intervention will focus on reducing hazards at home for older adults from specific zip codes so that a costly ER visit is averted.

**Outcome Measure Valuation:**
The Outcome measure was valued at 9.25% of the overall assigned project value for the associated Category 2 project in year 3, 9.25% in Year 4 and 9.25% in Year 5.

Houston Department of Health and Human Services (HDHHS) utilized the following method to determine the Category 2 project value:

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4) Cost Avoidance 5) Partnership Collaboration and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a predetermined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control
Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The Healthy Homes Fall Prevention project received a composite Prioritization score of 5.4 and a Public Health Impact score of 6.
### Performing Provider Name: City of Houston Health and Human Services

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Unique Category 2 identifier - 0937740-08.2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 [P-3]:</td>
<td>Process Milestone 2 [P-4]: Conduct</td>
</tr>
<tr>
<td></td>
<td>Plan Do Study Act cycle to continually</td>
</tr>
<tr>
<td></td>
<td>improve</td>
</tr>
<tr>
<td>Metric 1: Determine and provide</td>
<td>Metric 1: Document use of PDSA in planning</td>
</tr>
<tr>
<td>documentation of type of system</td>
<td>process</td>
</tr>
<tr>
<td>and IT resources needed.</td>
<td>Goal: Ensure systematic cyclical</td>
</tr>
<tr>
<td></td>
<td>quality improvement process</td>
</tr>
<tr>
<td></td>
<td>Data Source: Program Records</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated</td>
<td>Process Milestone 2 Estimated Incentive</td>
</tr>
<tr>
<td>Incentive Payment: $93,757.61</td>
<td>Payment: $109,685.90</td>
</tr>
<tr>
<td>Data Source: Program records and</td>
<td></td>
</tr>
<tr>
<td>documentation</td>
<td></td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 [P-5]:</td>
<td>Process Milestone 3 Estimated Incentive</td>
</tr>
<tr>
<td>Disseminate lessons learned and</td>
<td>Payment: $109,685.90</td>
</tr>
<tr>
<td>best practices</td>
<td></td>
</tr>
<tr>
<td>Metric 1: Documentation of best</td>
<td></td>
</tr>
<tr>
<td>practices and lessons learned</td>
<td></td>
</tr>
<tr>
<td>Goal: Share lessons learned and</td>
<td></td>
</tr>
<tr>
<td>best practices</td>
<td></td>
</tr>
<tr>
<td>Data Source: Program Records</td>
<td></td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 1 [IT-</td>
<td>Outcome Improvement Target 2 [IT-</td>
</tr>
<tr>
<td>9.4]: Other Outcome Improvement</td>
<td>9.4]: Other Outcome Improvement</td>
</tr>
<tr>
<td>Target (ED appropriate utilization)</td>
<td>target (ED appropriate utilization)</td>
</tr>
<tr>
<td>Metric 1: Home Safety/ Perception</td>
<td>Metric 1: Home Safety/ Perception of</td>
</tr>
<tr>
<td>of Home Safety survey completed</td>
<td>Home Safety survey completed among</td>
</tr>
<tr>
<td>among 90% of participants while</td>
<td>90% of participants while inspecting</td>
</tr>
<tr>
<td>inspecting homes; and of patients</td>
<td>homes; and of patients who undergo</td>
</tr>
<tr>
<td>who undergo home inspection, do</td>
<td>home inspection, do follow-up calls to</td>
</tr>
<tr>
<td>follow-up calls to determine</td>
<td>determine retention of knowledge.</td>
</tr>
<tr>
<td>retention of knowledge.</td>
<td></td>
</tr>
<tr>
<td>Metric 2: The number of falls</td>
<td>Metric 2: The number of falls among</td>
</tr>
<tr>
<td>among program participants since</td>
<td>program participants since the inspection.</td>
</tr>
<tr>
<td>the inspection.</td>
<td></td>
</tr>
<tr>
<td>Metric 3: The % of falls, that</td>
<td>Metric 3: The % of falls, that resulted in</td>
</tr>
<tr>
<td>resulted in 9-1-1 calls and/or</td>
<td>9-1-1 calls and/or ED visits among</td>
</tr>
<tr>
<td>ED visits among program</td>
<td>program participants.</td>
</tr>
<tr>
<td>participants.</td>
<td></td>
</tr>
<tr>
<td>Improvement Target: Increase by</td>
<td>Improvement Target: Increase by 10% Home</td>
</tr>
<tr>
<td>5% Home Safety and Perception</td>
<td>Safety and Perception of Home Safety Scores</td>
</tr>
<tr>
<td>of Home safety scores among</td>
<td>among program participants over baseline.</td>
</tr>
<tr>
<td>program participants over</td>
<td>Reduce by 5% each the number of falls since</td>
</tr>
<tr>
<td>baseline.</td>
<td>inspection and % of falls that result in</td>
</tr>
<tr>
<td></td>
<td>911 calls or ED visits among program</td>
</tr>
<tr>
<td></td>
<td>participants from baseline (Baseline</td>
</tr>
<tr>
<td></td>
<td>established in DY 3)</td>
</tr>
<tr>
<td>Data Source: Program Records, 911</td>
<td></td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 2</td>
<td></td>
</tr>
<tr>
<td>[IT-9.4]: Other Outcome</td>
<td></td>
</tr>
<tr>
<td>Improvement Target (ED</td>
<td></td>
</tr>
<tr>
<td>appropriate utilization)</td>
<td></td>
</tr>
<tr>
<td>Metric 1: Home Safety/ Perception</td>
<td></td>
</tr>
<tr>
<td>of Home Safety survey to completed</td>
<td></td>
</tr>
<tr>
<td>among 90% of participants while</td>
<td></td>
</tr>
<tr>
<td>inspecting homes; and of patients</td>
<td></td>
</tr>
<tr>
<td>who undergo home inspection, do</td>
<td></td>
</tr>
<tr>
<td>follow-up calls to determine</td>
<td></td>
</tr>
<tr>
<td>retention of knowledge.</td>
<td></td>
</tr>
<tr>
<td>Metric 2: The number of falls</td>
<td>Metric 2: The number of falls among</td>
</tr>
<tr>
<td>among program participants since</td>
<td>program participants since the inspection.</td>
</tr>
<tr>
<td>the inspection.</td>
<td></td>
</tr>
<tr>
<td>Metric 3: The % of falls, that</td>
<td>Metric 3: The % of falls, that resulted in</td>
</tr>
<tr>
<td>resulted in 911 calls made for</td>
<td>9-1-1 calls made for falls in older adults</td>
</tr>
<tr>
<td>falls in older adults 60 years and</td>
<td>60 years and over from specific zip codes</td>
</tr>
<tr>
<td>over from specific zip codes over</td>
<td></td>
</tr>
<tr>
<td>baseline.</td>
<td></td>
</tr>
</tbody>
</table>

**Data Source:** Program Records, 911 system
<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount: $93,757.61</th>
<th>Year 3 Estimated Outcome Amount: $219,371.80</th>
<th>Year 4 Estimated Outcome Amount: $233,531.11</th>
<th>Year 5 Estimated Outcome Amount: $507,796.98</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5)*: $1,054,457.51
Project Option 2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care

Unique Project ID: 0937740-08.2.2

Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. A similar pilot navigation program served 1074 clients last year, of which 60% were Medicaid patients, 15% were completely uninsured, 60% were African American, 30% were Hispanic and 8% were White and 2% were other race/ethnicity. This expansion project will serve 2000/year from DY4-5.

Intervention(s): CareHouston Links is a new program that proposes to provide care coordination and navigation that will reduce the frequency of non-urgent ambulance runs and ER visits and link 911 callers to appropriate primary and preventive care in lieu of unnecessary emergency room care.

Need for the Project: Current data shows that there are over 100,000 non-emergency transports made by Houston Fire Department (HFD) with certain zip codes having a high percentage of 911 calls. The CareHouston Links project will expand a program that has proven to reduce repeat calls to 911, through the use of face to face follow-up, education and navigation services among those with non-emergent conditions.

Target Population: All individuals that utilize Emergency Room (ER) for non-emergent, primary care needs and are transported by ambulance to the ER, will benefit from this project.

Category 1 or 2 expected patient benefits: During DY3, the program will enroll 80 patients/months in the navigation program. If patients were enrolled on target for 12 months of DY3, then the total number enrolled for DY3 would be 960. Our goal is to increase number of patients enrolled by 5% over baseline in DY4 (to 1008 new patients/year) and 10% over baseline numbers in DY5 (to 1056 new patients/year) the number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services, and enrolled in the program.

Category 3 outcomes:
IT-9.4: Other Improvement Target (ED Appropriate utilization for those needing non-emergent care and transported by ambulance and enrolled in this program). Our goal is to reduce by 5% below baseline the proportion of non-emergent ED visits (arrived by ambulance transportation) in DY4 and 7% below baseline in DY5 among those enrolled in the program

**Title of Outcome Measure (Improvement Target):** IT-9.4 Other Outcome Improvement Target

**Unique RHP Outcome identification number(s):** 0937740-08.3.5

**Performing Provider Name/TPI:** City of Houston Department of Health and Human Services/0937740-08

**Outcome Measure Description:**
IT-9.4 ED–Other Outcome Improvement Target (ED Appropriate Utilization)

- By providing patient navigation, non-emergent 911 callers and those that were seen by EMS can be redirected to the CareHouston Links Program. This program provides care coordination, by more accurately assessing the non-emergent 911 caller’s needs and connecting them to the required services. This will reduce unnecessary repeat calls to 911 and result in savings to the healthcare system.

**Process Milestones:**
- DY2:
  - P-3: Develop and Test Data System
- DY 3:
  - P-4: Conduct and Update Plan-Do-Study-Act for quality improvement
  - P-5: Disseminate findings, lessons learned and best practices

**Outcome Improvement Targets for each year:**
- DY 4:
  - IT-9.4 Other Outcome Improvement Target (ED appropriate utilization (Stand-alone measure) - Reduce ED visits that are non-emergent (including ACSC)
- DY 5:
  - IT-9.4 Other Outcome Improvement Target (ED appropriate utilization (Stand-alone measure) - Reduce ED visits that are non emergent (including ACSC)

**Rationale:**
A version of the proposed CareHouston Links program was previously targeted to the Sunnyside community in Southeast Houston where an HFD-EMS analysis showed that 26% of all 9-1-1 calls were non-emergency related in this low income, underserved community. Since the CareHouston program’s implementation in 2006, the HFD EMS unit experienced a 72% decrease in calls in this area allowing them to divert more than $4.6 million in costs associated with the transport of non-emergency callers to the emergency rooms for services. The CareHouston Links program will reduce future emergency room visits by providing navigation services to clients, educating them about the appropriate use of services and linking them with primary and preventive care services. Ineffective navigation of the health care system by patients may lead to poorer outcomes and inefficiencies because of delayed care, failure to receive proper care or treatments, or care being received in more expensive locations (i.e., emergency rooms).

Linking, assessing and referring clients to appropriate services will reduce their need to use emergency services. Each time an ambulance service is dispatched to transport patients; the cost is approximately $1470. During Fiscal Year 2012, the Care Houston program diverted...
1,458 clients from using EMS transports to emergency departments for non-emergencies, saving the COH $2,143,260. Each diverted ambulance transport is also associated with a diverted emergency room visit.  

The Other Improvement Target for Reducing Inappropriate ER Use, will be used as our Category 3 Outcome measure. According to Agency for Healthcare Research and Quality, visits to the Emergency Department for non emergent care results in increasing health care costs and overcrowding. A report from Health and Human Services Commission on Rider 56, House Bill 1, from August 2012, states “one of the key strategies to reducing non-emergent ED use is to steer clients to more appropriate sources of care. Integral to achieving this goal is ensuring adequate access to prevention and primary care services. The medical home model is a building block to achieving this objective as is promoting the use of urgent care facilities and retail health clinics when clients cannot go to their medical home.” (Article II, Health and Human Services Commission, Rider 56, H.B. 1, 82nd Legislature, Regular Session, 2011).

**Outcome Measure Valuation:**

The Outcome measure was valued at 11.41% of the overall assigned project value for the associated Category 2 project in year 3, 11.41% in Year 4 and 11.41% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HHDHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HHDHS Valuation Tool). HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4) Cost Avoidance 5) Partnership Collaboration and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HHDHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HHDHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The CareHouston Links Program received a composite Prioritization score of 7.15 and a Public Health Impact score of 7. The following are avenues of cost savings to the health care system that can be facilitated by a program that seeks to reduce ER usage, such as CareHouston Links.

1. Cost savings attributed to using navigators as part of a preventable ED reduction program
2. Cost savings related to connecting patients to medical homes, increase access to primary and specialty care, and increase access to chronic care management
3. CMS reimbursement rate for EMS transports; Cost savings to CMS when alternate transportation is used
4. Cost savings to CMS for ED visit redirected to a clinic

References:
5. ER Visits with an ambulance transport. Report from Center for Health Services Research Collaborative, UT School of Public Health, Houston, Texas. Accessed on 10/2/12 from https://sph.uth.edu/research/centers/chsr/hsrc/. Stakeholder input from RHP 3 Working Group Members throughout the Region (including providers, consumers, hospital and clinic administrators, government officials, researchers, and advocacy groups)
### Performing Provider Name: City of Houston Health and Human Services

**Unique Cat 2 ID:** 0937740-08.2.2

**TPI – 0937740-08**

### Related Category 1 or 2 Projects:

- **Unique Cat 2 ID:** 0937740-08.2.2

### Starting Point/Baseline:

**Baseline will be established in DY 2-3**

### Year 2

**Starting Point/Baseline:**

- **(10/1/2012 – 9/30/2013)**

**Process Milestone 1 (P-3):** Develop and Test Data System

- **Metric 1:** Provide documentation of IT resources and system needed

- **Metric 2:** Documentation of testing and installation of data system
  - Goal: Set up a workable electronic system through which effective and efficient data can be collected.
  - Data Source: Program documentation and electronic system.

**Process Milestone 1 Estimated Incentive Payment:** $115,664.23

### Year 3

**Starting Point/Baseline:**

- **(10/1/2013 – 9/30/2014)**

**Process Milestone 2 (P-4):** Conduct Plan Do Study Act cycle to continually improve

- **Metric 1:** Document use of PDSA in planning process
  - Goal: Ensure highest quality on program process and improvement.
  - Data Source: Step-wise documentation of PDSA in program documentation

**Process Milestone 2 Estimated Incentive Payment:** $135,314.19

**Process Milestone 3 (P-5):** Disseminate lessons learned and best practices

- **Metric 1:** Documentation of best practices and lessons learned
  - Goal: Provide report documenting identification of best practices and lessons learned
  - Data Source: Documentation of report

**Process Milestone 3 Estimated Incentive Payment:** $135,314.19

### Year 4

**Starting Point/Baseline:**

- **(10/1/2014 – 9/30/2015)**

**Outcome Improvement Target 1 (IT-9.4):** Other Improvement Target (Stand-alone measure)

- **Improvement Target:** Reduce all ED visits that are non-emergent (including ACSC) in specific zip codes due to participation in Navigation Program by 5% below baseline the proportion of non-emergent ED visits

- **Data source:** Program data electronic records, EMS Data (Baseline will be established in Yr. 2-3 from program data by establishing the proportion of non-emergent 911 callers that were connected to CareHoustonLinks.)

**Outcome Improvement Target 1 Estimated Incentive Payment:** $288,096.03

### Year 5

**Starting Point/Baseline:**

- **(10/1/2015 – 9/30/2016)**

**Outcome Improvement Target 2 (IT-9.4):** Other Improvement Target (Stand-alone measure)

- **Improvement Target:** Reduce all ED visits that are non-emergent (including ACSC) in specific zip codes due to participation in Navigation Program by 5% below Yr. 4 the proportion of non-emergent ED visits that were averted during enrollment in the program

**Data source:** Program data electronic records, EMS Data

**Numerator:** Non Emergent 911 callers connected to CareHouston Links, who would have otherwise been transported to ED

**Denominator:** All non-Emergent 911 callers

**Outcome Improvement Target 2 Estimated Incentive Payment:** $626,444.56
<table>
<thead>
<tr>
<th>Performing Provider Name: City of Houston Health and Human Services</th>
<th>TPI – 0937740-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>Unique Cat 2 ID: 0937740-08.2.2</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be established in DY 2-3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: $115,664.23</td>
<td>Year 3 Estimated Outcome Amount: $270,628.37</td>
<td>Year 4 Estimated Outcome Amount: $288,096.03</td>
<td>Year 5 Estimated Outcome Amount: $626,444.56</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $1,300,833.19
**Project Option - Project Option 2.9.1- Establish/Expand a Patient Care Navigation Program**

**Unique Project ID:** 0937740-08.2.3

**Performing Provider Name/TPI:** City of Houston Department of Health and Human Services/0937740-08

**Project Summary:** Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs.

**Intervention(s):** This expansion project will use patient navigators to connect 270 new at risk HIV diagnosed individuals to appropriate care in the baseline year. Linkage to care will consist of active referrals to primary medical care, mental health, substance abuse, support services, and services for basic needs such as food and housing. Utilizing a Community-Based (Non-Medical) Case Management model, this program will also Identify frequent ED utilizers and use navigators as part of a preventable ED reduction program.

**Need for the Project:** Newly diagnosed HIV patients are frequently at risk for receiving fragmented care because of being disconnected from the health care system. This project will support HIV patients through the continuum of health care services so that patients can receive coordinated, timely services when needed with smooth transitions between health care settings. The race/ethnicity of patients in HIV linkage program last year were 68% African American, 29% Hispanic and 3% White.

**Target Population:** Newly diagnosed HIV patients will be the target group for this project. In particular, belonging to high risk groups such as males, blacks/African Americans, and Injection drug users will be the targets because they are known to have lower service linkage rates than the average for the Houston region.

**Category 1 or 2 expected patient benefits:** Increase number of PCP referrals for indigent or Medicaid patients without a medical home who use the ED, urgent care, and/or hospital services by 5% over baseline (baseline of 275 patients) in DY4 (288 patients in DY4) and by 10% over baseline in DY5 (303 patients in DY5).

**Category 3 outcomes:**

**IT-9.4:** (ED appropriate utilization) Reduce by 5% each the number of ED visits among program participants in HIV Linkage Program and number of from specific zip codes over baseline in DY4 and by 10% over baseline in DY5.
Title of Outcome Measure (Improvement Target): IT-9.4 Other Outcome Improvement Target(ED appropriate utilization)(Stand-alone measure)

Unique RHP Outcome identification number(s): 0937740-08.3.6

Outcome Measure Description:
IT-9.4 Other Outcome Improvement Target(ED appropriate utilization)
The performing provider proposes to provide navigation services to targeted HIV patients who are at high risk of disconnect from institutionalized health care is critical to reduce ED and inpatient use for potentially preventable admissions in HIV patients. Providing navigation services to targeted HIV patients who are at high risk of disconnect from institutionalized health care is critical to reduce ED and inpatient use for potentially preventable admissions in HIV patients.

Numerator: Number of HIV patients enrolled in program that used ER in past 6 months
Denominator: Total number of HIV patients enrolled in Service Linkage Program during the same time period
Data Source: Service Linkage Database and follow up data

Process Milestones:
- DY2:
  - P-X1 Development of Outreach and Education Plan
- DY 3:
  - P-4 Metric: Conduct Plan-Do-Study-Act
  - P-5 Milestone: Disseminate findings, lessons learned and best practices

Outcome Improvement Targets for each year:
- DY 4:
  - IT-9.4 Other Outcome Improvement Target(ED appropriate utilization) Reduce rate of ER visits that are non emergent among HIV patients enrolled in Service Linkage program in past 6 months by 3% over baseline
- DY 5:
  - IT-9.4 Other Outcome Improvement Target (ED appropriate utilization) Reduce rate of ER visits that are non emergent among HIV patients enrolled in Service Linkage program in past 6 months by 6% over baseline.

Rationale:
Patient care navigation has been established as a best practice to improve the care of populations at high risk of being disconnected from health care institutions. Tying inpatient and outpatient care can help integrate inpatient and outpatient services and promote accountability for the coordination, cost and quality of care. This service linkage expansion will provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others).

Outcome Measure Valuation:
The Outcome measure was valued at 10.71% of the overall assigned project value for the associated Category 2 project in year 3, 10.71% in Year 4 and 10.71% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.
HDDHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HHDHS Valuation Tool). HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the
following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4) Cost Avoidance 5) Partnership Collaboration and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a predetermined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The HIV Service Linkage Expansion received a composite Prioritization score of 6.5 and a Public Health Impact score of 6.
Performing Provider Name: City of Houston Health and Human Services

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Unique Category 2 Identifier - 0937740-08.2.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>HDHHS -0937740-08</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-X1]:</strong> Development of Outreach and Education Plan to Target population</td>
<td><strong>Process Milestone 2 [P-4]:</strong> Conduct Plan Do Study Act cycle to continually improve</td>
<td><strong>Outcome Improvement Target 2 [IT-9.4]:</strong> Other Outcome Improvement Target (ED appropriate utilization)</td>
<td><strong>Outcome Improvement Target 4 [IT-9.4]:</strong> Other Outcome Improvement Target (ED appropriate utilization)</td>
</tr>
<tr>
<td>Metric: Written report on Outreach Education Plan for Service Linkage Program</td>
<td>Metric: Document use of PDSA in planning process</td>
<td>Improvement Target: Reduce number of ED visits in Program enrollees by 3% in 6 months over Baseline</td>
<td>Improvement Target: Reduce number of ED visits in Program enrollees by 6% over Baseline</td>
</tr>
<tr>
<td>Goal: To disseminate information about program in Target Population</td>
<td>Goal: Utilize a cyclical quality improvement process</td>
<td>Numerator: Number of HIV patients enrolled in program that used ER in past 6 months</td>
<td>Numerator: Total number of HIV patients enrolled in program that used ER in Service Linkage Program.</td>
</tr>
<tr>
<td>Data Source: Program Documentation</td>
<td>Milestone 2 Estimated Incentive Payment: $126,945.97</td>
<td>Denominator: Total number of HIV patients enrolled in Service Linkage Program.</td>
<td>Denominator: Total number of HIV patients enrolled in Service Linkage Program.</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment: $108,511.22</td>
<td><strong>Process Milestone 3 [P-5]:</strong> Disseminate lessons learned and best practices</td>
<td>Data Source: Service Linkage Database and follow up data</td>
<td>Data Source: Service Linkage Database and follow up data</td>
</tr>
<tr>
<td></td>
<td>Metric: Documentation of best practices and lessons learned</td>
<td><strong>Outcome Improvement 4 Estimated Incentive Payment: $270,279.35</strong></td>
<td><strong>Outcome Improvement 5 Estimated Incentive Payment: $587,703.42</strong></td>
</tr>
<tr>
<td></td>
<td>Goal: Share lessons learned</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data Source: Program Documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Milestone 3 Estimated Incentive Payment: $126,945.97</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $108,511.22</td>
<td>Year 3 Estimated Outcome Amount: $253,891.84</td>
<td>Year 4 Estimated Outcome Amount: $270,279.35</td>
<td>Year 5 Estimated Outcome Amount: $587,703.42</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $1,220,385.93
Project Option - 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (TB patients or suspected TB patients)

Unique Project ID: 0937740-08.2.4

Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

Last year, a similar project with a smaller scope, utilizing just two testing modalities served 396 TB patients, of which 119 were completely uninsured. 103 of these were African Americans and 191 were White Hispanic. This project intends to serve 750 individuals in DY3, 788 individuals in DY 4 and 825 individuals in DY5 per year to improve TB outcomes.

Intervention(s): The performing provider will implement interventions to rapidly identify, treat and short recovery to reduce TB morbidity for TB patients, contacts of foreign born TB cases and suspected cases enrolled in this project by utilizing three testing and technology (Nucleic Amplification Test, QuantiFERON test and combined INH and RPT tests to meet its goals.

Need for the Project: This project provides a community level, comprehensive evidence based care to patients that have active or latent TB, and their contacts and suspects. The project will rapidly and accurately identify cases and provide a short term therapy that cuts down on number of days of hospital stay.

Target Population: The target population will be at risk vulnerable populations such as the homeless, chronically ill low income population, refugee and new immigrant population, indigent, those without access to care or without a medical home who are routinely reported to the performing provider for active or latent TB.

Category 1 or 2 expected patient benefits: Increase the number or percent of patients in defined population receiving innovative intervention at DY3 baseline total (230 individuals) consistent with evidence-based model by 5% over baseline in DY4 (242 individuals) and by 10% (254 individuals) over baseline in DY5. Estimated patient impact -DY3: NAAT - 50, 3HP - 80, QFT – 100; DY 4: NAAT - 53, 3HP - 84, QFT – 105; DY5: NAAT - 56, 3HP - 88, QFT - 110.
Category 3 outcomes: The two category 3 outcomes are 1) IT-4.10 Other Outcome Improvement Target: Average length of stay for patients diagnosed with TB. Decrease average length of stay by 2% in DY4 and by 5% over baseline in DY5. 2) IT-6.1 Increase in patient satisfaction scores for patients enrolled in program by 5% over baseline in DY4 and by 10% over baseline in DY5.

Title of Outcome Measure (Improvement Target): IT-4.10 Other Outcome Improvement Target: Average length of stay for patients diagnosed with TB.

Unique RHP Outcome identification number(s): 0937740-08.3.7
Performing Provider Name/TPI: City of Houston Department of Health and Human Services /0937740-08

Outcome Measure Description:
Outcome Improvement Target 1 [IT-4.10] Other Outcome Improvement Target: Average length of stay for patients diagnosed with TB.
Numerator: Total number of inpatient days for patients diagnosed with TB
Denominator: Total number of patients diagnosed with TB contacted by TB Program

Process Milestones:

- DY 3:
  - P-3: Develop and test data systems
  - P-7: Initiate patient satisfaction measures to evaluate program and put QI in place.

Outcome Improvement Targets for each year:

- DY 4:
  - IT-4.10 Other Outcome Improvement Target: Reduce Average length of stay for patients diagnosed with TB by 2% over Baseline

- DY 5:
  - IT-4.10 Other Outcome Improvement Target: Average length of stay for patients diagnosed with TB by 5% over Baseline

Rationale:
We chose the outcome improvement target IT-4.10 Other Outcome Improvement Target: Average length of stay for patients diagnosed with TB. The comprehensive testing package to ensure early diagnosis, accurate diagnosis and reduction in number of days of treatment will help us achieve our goals. By providing tests that conduct rapid and accurate identification, short duration of therapy and connecting patients to primary care, where they can receive appropriate care decreases the likelihood of length of stay in the hospital. The performing provider (Houston TB Bureau) will utilize the CDC guidelines to accurately and rapidly identify and rule out TB disease for this project. Based on guidelines from Texas Department of State Health Services Tuberculosis Branch standing delegation orders, the Houston TB Bureau will implement the use of 3HP in the treatment latent tuberculosis patients in order to increase patient compliance and completion of LTBI therapy and decrease the number of patient at risk for progression to active TB disease. Studies have shown about 5 to 10 percent of those with latent TB infection in the
United States will develop TB disease if not treated. People with latent TB infection who have weakened immune systems, including those with HIV/AIDS or diabetes, are more likely to develop TB disease after infection. For those reasons, treatment is important (3). These potential future TB cases could be admitted to hospitals for diagnoses and treatment.

CDC recommends a minimum of two week hospital stay for patients who are infectious with a positive bacteriology smear results. This project plans to reduce the number of hospital days during admissions for treatment of tuberculosis every year and preventing future TB cases. These efforts will provide cost savings to the health care system.

**Outcome Measure Valuation:**
The Outcome measure was valued at 11.67% of the overall assigned project value for the associated Category 2 project in year 3, 11.67% in Year 4 and 11.67% in Year 5. HHDHS utilized the following method to determine the Category 2 project value. HHDHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HHDHS Valuation Tool). HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4) Cost Avoidance 5) Partnership Collaboration and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HHDHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HHDHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The TB Rapid Identification, Treatment and Recovery Project received a composite Prioritization score of 7.15 and a Public Health Impact score of 7.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Unique Category 2 Identifier - 0937740-08.2.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process</strong></td>
<td><strong>Process Milestone 1 [P-3]: Develop and test data systems.</strong>&lt;br&gt;Metric: Provide evidence of a viable data system to capture evaluation data.&lt;br&gt;Goal: To have an efficient data collection system.&lt;br&gt;Data Source: Program Documentation&lt;br&gt;Process Milestone 2 Estimated Incentive Payment: $69,148.94</td>
<td><strong>Outcome Improvement Target 1 [IT-4.10] Other Outcome Improvement Target: Average length of stay for patients diagnosed with TB.</strong>&lt;br&gt;Improvement Target: Decrease average length of hospital stay by 2% over baseline&lt;br&gt;Data Source: Hospital and Program data&lt;br&gt;Outcome Improvement Target 1 Estimated Incentive Payment: $147,224.31</td>
<td><strong>Outcome Improvement Target 3 [IT-4.10] Other Outcome Improvement Target: Average length of stay for patients diagnosed with TB.</strong>&lt;br&gt;Improvement Target: Decrease average length of hospital stay by 5% over baseline&lt;br&gt;Data Source: Hospital and Program data&lt;br&gt;Outcome Improvement Target 2 Estimated Incentive Payment: $320,128.90</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-5]: Disseminate lessons learned and best practices</strong>&lt;br&gt;Metric: Documentation of best practices and lessons learned&lt;br&gt;Goal: Share lessons learned&lt;br&gt;Data Source: Program Documentation&lt;br&gt;Process Milestone 2 Estimated Incentive Payment: $69,148.94</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $0</td>
<td>Year 3 Estimated Outcome Amount: $138,297.89</td>
<td>Year 4 Estimated Outcome Amount: $147,224.31</td>
<td>Year 5 Estimated Outcome Amount: $320,128.90</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $605,651.10
**Project Option - 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (TB patients or suspected TB patients)**

**Unique Project ID:** 0937740-08.2.4

**Performing Provider Name/TPI:** City of Houston Department of Health and Human Services/0937740-08

**Project Summary:** Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

Last year, a similar project with a smaller scope, utilizing just two testing modalities served 396 TB patients, of which 119 were completely uninsured. 103 of these were African Americans and 191 were White Hispanic. This project intends to serve 750 individuals in DY3, 788 individuals in DY 4 and 825 individuals in DY5 per year to improve TB outcomes.

**Intervention(s):** The performing provider will implement interventions to rapidly identify, treat and short recovery to reduce TB morbidity for TB patients, contacts of foreign born TB cases and suspected cases enrolled in this project by utilizing three testing and technology (Nucleic Amplification Test, QuantiFERON test and combined INH and RPT tests to meet its goals.

**Need for the Project:** This project provides a community level, comprehensive evidence based care to patients that have active or latent TB, and their contacts and suspects. The project will rapidly and accurately identify cases and provide a short term therapy that cuts down on number of days of hospital stay.

**Target Population:** The target population will be at risk vulnerable populations such as the homeless, chronically ill low income population, refugee and new immigrant population, indigent, those without access to care or without a medical home who are routinely reported to the performing provider for active or latent TB.

**Category 1 or 2 expected patient benefits:** Increase the number or percent of patients in defined population receiving innovative intervention at DY3 baseline total (230 individuals) consistent with evidence-based model by 5% over baseline in DY4 (242 individuals) and by 10% (254 individuals) over baseline in DY5. Estimated patient impact - DY3: NAAT - 50, 3HP - 80, QFT – 100; DY 4: NAAT - 53, 3HP - 84, QFT – 105; DY5: NAAT - 56, 3HP - 88, QFT - 110.
Category 3 outcomes: The two category 3 outcomes are 1) IT-4.10 Other Outcome Improvement Target: Average length of stay for patients diagnosed with TB. Decrease average length of stay by 2% in DY4 and by 5% over baseline in DY5. 2) IT-6.1 Increase in patient satisfaction scores for patients enrolled in program by 5% over baseline in DY4 and by 10% over baseline in DY5.

Title of Outcome Measure (Improvement Target): IT 6.1 Percent improvement over baseline of patient satisfaction scores- patient’s overall health status/functional status. (Standalone measure)

Unique RHP Outcome identification number(s): 0937740-08.3.8

Outcome Measure Description:
Outcome Improvement Target 1 [IT-6.1] Other Outcome Improvement Target: Patient satisfaction scores for patients diagnosed with TB.
Scoring: Increase in scores from Patient Satisfaction Questionnaire from RAND Health by 5% over baseline in DY4 and 10% over baseline in DY5.

Process Milestones:
• DY2:
  o P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
• DY 3:
  o P-4 Metric: Conduct Plan-Do-Study-Act
  o P-7:Initiate patient satisfaction measures to evaluate program and put QI in place

Outcome Improvement Targets for each year:
• DY 4: IT-6.1 Other Outcome Improvement Target: Increase in patient satisfaction scores for patients enrolled in program by 5% over baseline in DY4.
• DY 5: IT-6.1 Other Outcome Improvement Target: Increase in patient satisfaction scores for patients enrolled in program by 10% over baseline in DY5.

Rationale:
We chose the outcome improvement target IT-6.1 Other Outcome Improvement Target: Patient satisfaction scores. We will measure an increase in scores from Patient Satisfaction Questionnaire from RAND Health by 5% over baseline in DY4 and 10% over baseline in DY5. Patient satisfaction has been shown to be an important factor in adherence to treatment and this is particularly poorly understood for TB patients. According to CDC, patient satisfaction is how individuals regard the health care services or the manner in which they are delivered by health care providers as useful, effective, or beneficial. It is often based on patient expectations of care and the self-assessment of their experiences. Patient satisfaction may play a major role in a patient’s behaviors. If a patient is dissatisfied with the relationship with their provider or with the clinical setting, he or she is much less likely to be adherent to medications, keeping appointments, identifying contacts, and so forth. Research has shown that patient satisfaction can be increased with effective patient-provider communication and development of a trusting relationship.
CDC recommends a minimum of two week hospital stay for patients who are infectious with a positive bacteriology smear results. This project plans to reduce the number of hospital days during admissions for treatment of tuberculosis every year and preventing future TB cases. These efforts will provide cost savings to the health care system.

**Outcome Measure Valuation:**
The Outcome measure was valued at 11.67% of the overall assigned project value for the associated Category 2 project in year 3, 11.67% in Year 4 and 11.67% in Year 5. HDHHS utilized the following method to determine the Category 2 project value.

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4) Cost Avoidance 5) Partnership Collaboration and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The TB Rapid Identification, Treatment and Recovery Project received a composite Prioritization score of 7.15 and a Public Health Impact score of 7.
<table>
<thead>
<tr>
<th>Performing Provider Name: City of Houston Health and Human Services</th>
<th>Other Outcome Improvement Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>HDHHS -0937740-08.3.8</td>
<td>IT -6.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Unique Category 2 Identifier - 0937740-08.2.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-4]: Conduct Plan Do Study Act cycle to continually improve</td>
<td>Outcome Improvement Target 1 [ IT-6.1] Percent improvement over baseline of patient satisfaction scores- patient’s overall health status/functional status. (Standalone measure)</td>
<td>Outcome Improvement Target 4 [ IT-6.1] Percent improvement over baseline of patient satisfaction scores- patient’s overall health status/functional status. (Standalone measure)</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $118,214.65</td>
<td>Goal: Utilize a cyclical quality improvement process</td>
<td>Denominator: Number of patients who were administered the survey</td>
<td>Denominator: Number of patients who were administered the survey</td>
</tr>
<tr>
<td></td>
<td>Data Source: PDSA documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 [P-7]: Initiate patient satisfaction measures to evaluate program and put QI in place</td>
<td>Metric: Documentation of patient satisfaction practices and lessons learned</td>
<td>Outcome Improvement Target 1 [ IT-6.1] Estimated Incentive Payment: $147,224.31</td>
<td>Outcome Improvement Target 2 [ IT-6.1] Estimated Incentive Payment: $320,128.90</td>
</tr>
<tr>
<td>Goal: Share results and lessons learned</td>
<td>Data Source: Program Documentation</td>
<td>$69,148.94</td>
<td>$320,128.90</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $69,148.94</td>
<td></td>
<td>$147,224.31</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $118,214.65</td>
<td>Year 3 Estimated Outcome Amount: $138,297.89</td>
<td>Year 4 Estimated Outcome Amount: $147,224.31</td>
<td>Year 5 Estimated Outcome Amount: $320,128.90</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $723,865.75
**Project Option 2.2.6 - Expand Chronic Care Management Models “Other” project option**

**Unique Project ID: 0937740-08.2.5**

**Performing Provider Name/TPI:** City of Houston Department of Health and Human Services/0937740-08

**Project Summary:**

Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs.

Intervention(s): The Diabetes Awareness and Wellness Network (DAWN) Center is a new initiative serving 400 participants at baseline (75 diagnosed diabetics, 125 with pre-diabetes glucose levels and 200 community members at risk for diabetes) per year from DY 3-5. The Center will provide complementary wellness programming and offer prevention and intervention services and coordination of care for those with diabetes or at risk for diabetes through enhanced education, physical activity, self-management education, hemoglobin A1C tracking and monitoring, BMI measurements, behavioral change coaching, and case management. Participants will be recruited from 3 FQHC’s, County Hospital based diabetes center and one dialysis center that all serve low income Medicaid patients.

Need for the Project: Comprehensive disease management can reduce costs based on less hospitalizations, decrease in loss of productivity, decrease in absenteeism, and decrease in unemployment from disease-related disability. Diabetes patients or those at risk for diabetes receive the greatest benefit from disease management or health enhancing behaviors to lower their risks to develop diabetes.

Target Population: Individuals with diabetes or at risk for diabetes residing in an underserved area (Third Ward) with a high incidence of diabetes will benefit from the comprehensive wellness program.

Category 1 or 2 expected patient benefits: Increase proportion of patients with disease self-management goals in the DAWN Center by 5% over baseline in DY 4 and by 10% over baseline in DY5. The baseline year will serve a target of 200 (diagnosed diabetics and pre-diabetics), in DY4 the Center will serve 210 new diabetics and pre-diabetics and in DY5 the Center will serve 220 new diagnosed diabetics and pre-diabetics that have disease self-management goals. The DAWN Center itself will serve an additional 200 community members/year (in addition to the pre-diabetic and diabetic patients) that are deemed to be at risk for developing diabetes (identified through the American Diabetes Association risk assessment tool).
Category 3 outcomes: IT-1.10 Diabetes care: Decrease proportion of patients with HbA1c poor control by 2% over baseline in Wellness Center enrollees in DY4 and IT-1.10 Diabetes care: Decrease HbA1c poor control by 5% over baseline in DAWN enrollees in DY5.

Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes care: *HbA1c poor control (>9.0%)*

Unique RHP Outcome Identification Number: 0937740-08.3.9

Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Outcome Measure Description:

IT-1.10 Diabetes care: *HbA1c poor control (>9.0%)*

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

Numerator: Percentage of patients 18-75 years of age with diabetes (Type 1 or Type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.

Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (Type 1 and Type 2)

Process Milestones:

- DY 2
  - P-7: Milestone: Conduct Community Education and Outreach
- DY 3
  - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve
  - P-5: Milestone: Disseminate lessons learned and best practices

Outcome Improvement Target(s) for each year:

- DY 4:
  - IT-1.10 Diabetes care: Decrease HbA1c poor control by 2% over baseline in DAWN enrollees (>9.0%)17- NQF 0059 (Stand-alone measure)
    - a Numerator: Percentage of patients 18-75 years of age with diabetes (Type 1 or Type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
    - b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (Type 1 and Type 2)
  - c Data Source: DAWN Case Management Registry
- DY 5:
  - IT-1.10 Diabetes care: Decrease HbA1c poor control by 5% over baseline in DAWN enrollees (>9.0%)17- NQF 0059 (Stand-alone measure)
    - a Numerator: Percentage of patients 18-75 years of age with diabetes (Type 1 or Type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
    - b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (Type 1 and Type 2)
  - c Data Source: DAWN Case Management Registry
Rationale:

The process and improvement targets have been chosen based on the project goals of chronic care self-management, care transitions, self-management goal setting, and a community based coordinated system of care. Clinically healthy range for HbA1c is less than 5.7 %, values between 5.7% and 6.4% are considered pre-diabetes and values higher than 6.4 are referred to as diabetes. For a diabetic patient, it is recommended to maintain the HbA1C level below 6.5-7 % (1). HbA1C indicates how well one is controlling the blood sugar over the last 60-90 days, which helps the patients and their care providers to adjust the diet, physical activity and medication accordingly. HbA1C is also considered as the’ gateway’ to care for individuals with type-2 diabetes. This project involves establishing a comprehensive Diabetes Wellness Center will offer a community based center in an underserved community with one of the highest incidence of diabetes.

According to the Houston Hospitalizations at a Glance Report, chronic conditions accounted for 78% of all adult preventable hospitalizations in Houston, with 26% of those being related to diabetes. This same report indicates that in Council District D, (most consistent with the targeted service area of the DAWN Center) the annual average cost of adult preventable hospitalizations for District D is $69,644,160 (the highest annual average cost for any District). Additionally, 22% of adult preventable hospitalizations in District D are diabetes-related. City Council District D has the second highest number of preventable diabetes hospitalizations (2,420). It also has the highest average cost per discharge of adult preventable hospitalizations by Council District ($32,038).

Additionally, the literature (Economic Costs of Diabetes in the U.S. in 2007, Diabetes Care31: 596-615, 2008) indicates that a program similar to the Diabetes Awareness and Wellness Network (DAWN) Center that focuses on enhanced education, physical activity, self-management education, hemoglobin A1C tracking and monitoring, BMI measurements, behavioral change coaching, and case management can reduce costs based on less hospitalizations, decrease in loss of productivity decrease in absenteeism, and decrease in unemployment from disease-related disability.


Outcome Measure Valuation:

The Outcome measure was valued at 11.67% of the overall assigned project value for the associated Category 2 project in year 3, 11.67% in Year 4 and 11.67% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HDDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4) Cost Avoidance 5) Partnership Collaboration and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.
Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category. HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. DAWN received a composite Prioritization score of 7.10 and a Public Health Impact score of 7.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Diabetes care: HbA1c poor control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing Provider Name: City of Houston Department of Health and Human Services HDHHS - 0937740-08.2.5</td>
<td></td>
</tr>
</tbody>
</table>

### Year 2 (10/1/2012 – 9/30/2013)

**Process Milestone 1 [P-7]:** Conduct community education and outreach to build awareness about Diabetes risks (mortality, prevalence and control)

**Metric 1:** Documentation of at least ten unique outreach activities/products in target community in DY 2
- Goal: Build awareness of diabetes in target community
- Data Source: Program Documentation, Outreach Materials, Meeting Minutes

**Milestone 1 Estimated Incentive Payment:** $118,220.28

**Year 3 (10/1/2013 – 9/30/2014)**

**Process Milestone 2 [P-4]:** Conduct Plan Do Study Act cycle to continually improve

**Metric 1:** Document use of PDSA in planning process
- Goal: development of report documenting use of PDSA in planning process
- Data Source: Report documentation

**Milestone 2 Estimated Incentive Payment:** $138,304.48

**Process Milestone 3 [P-5]:** Disseminate lessons learned and best practices to stakeholders

**Metric 1:** Documentation of best practices and lessons learned
- Goal: Development of report documenting best practices and lessons learned
- Data Source: Report documentation Process Milestone 3

**Milestone 3 Estimated Incentive Payment:** $138,304.48

**Year 4 (10/1/2014 – 9/30/2015)**

**Outcome Improvement Target 1 [IT-1.10]:** HbA1c poor control (>9.0%) - NQF 0059 (Stand-alone measure)
- Goal: Decrease the proportion of patients who have poor HbA1C control by 2% over baseline
- Data Source: Case Management Registry

**Numerator:** Number of patients 18-75 years of age with diabetes (Type 1 or Type 2) who had hemoglobin A1c (HbA1c) control > 9.0% enrolled in DAWN

**Denominator:** DAWN Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (Type 1 and Type 2)

**Outcome Improvement Target 1 Estimated Amount:** $294,462.64

**Year 5 (10/1/2015 – 9/30/2016)**

**Outcome Improvement Target 3 [IT-1.10]:** HbA1c poor control (>9.0%) - NQF 0059 (Stand-alone measure)
- Goal: Decrease the proportion of patients who have poor HbA1C control by 5% over baseline
- Data Source: Case Management Registry

**Numerator:** Number of patients 18-75 years of age with diabetes (Type 1 or Type 2) who had hemoglobin A1c (HbA1c) control > 9.0% enrolled in DAWN

**Denominator:** DAWN Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (Type 1 and Type 2)

**Outcome Improvement Target 3 Estimated Amount:** $640,288.30

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $1,329,580.18

**Year 2 Estimated Outcome Amount:** $118,220.28

**Year 3 Estimated Outcome Amount:** $276,608.96

**Year 4 Estimated Outcome Amount:** $294,462.64

**Year 5 Estimated Outcome Amount:** $640,288.30

**Regional Healthcare Partnership Plan Region 3**

**1762**
Project Option 2.13.2 - Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner.

**Unique Project ID:** 0937740-08.2.6

**Performing Provider Name/TPI:** City of Houston Department of Health and Human Services/0937740-08

**Project Summary:** Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

**Intervention(s):** The performing provider will conduct monitoring, screening, assessment, service plan development and linking participants to care (if willing) for a maximum of individuals (N=8000/year) and a minimum of N=6000/year, who frequently display a range of mental and physical symptoms that indicate alcohol or other substance abuse in DY4-5.

**Need for the Project:** The new Sobering Center initiative provides a short term facility where individuals arrested for being under the influence of alcohol or other substances need a facility where they are under medical supervision but not utilizing valuable health care resources at other settings such as hospitals admissions or the ER.

**Target Population:** The target population will be individuals that have been arrested by the Police Department for alcohol or other substance abuse issues and are taken to the Sobering Center. More than 75% are indigent, on Medicaid or homeless.

**Category 1 or 2 expected patient benefits:** 5% decrease over baseline in preventable admissions and readmissions into Criminal Justice System of those who were previously arrested for public intoxication and have participated in Sobering Center program in past 6 months in DY4 and 7% decrease over baseline in DY5. In DY3, it is expected that a baseline will be established of serving 500 contacts/month or 6000 contacts per year will be established when Center is operating fully. In DY4, this will decrease to 475 contacts/month and in DY5 it will decrease further by 7% from baseline to 465 contacts/month.

**Category 3 outcomes:** IT-9.4 Other: Decrease preventable admissions to ER/hospitals/criminal justice setting due to non-emergent alcohol/other substance use intoxication in a 6 month period by 2% over baseline in DY4 and by 4% in DY5.
Title of Outcome Measure (Improvement Target): IT-9.4 Other Outcome Improvement Target; (Non emergent ER visits and hospitalizations in Sobering Center Participants)

Unique RHP Outcome identification number(s): 0937740-08. 3.10

Performing Provider Name/TPI: City of Houston Department of Health and Human Services / 0937740-08

Outcome Measure Description:
IT – 9.4 Other Outcome Improvement Target (Non emergent ER visits and hospitalizations in Sobering Center Participants)
Rate: Preventable admissions to ER and hospitals due to non emergent alcohol/other substance use intoxication symptoms in Sobering Center Participants in previous 6 month period
The performing provider, along with its partner, the Houston Police Department will establish a short-term care facility called the “Sobering Center”, designed as a medically supervised location to transport and house individuals who are under the influence of alcohol or other substances. Many of these individuals would either travel to or are taken to the emergency room for follow up care and the Sobering Center will serve as an alternative to a non emergent ER Visit. Others recycle through the criminal justice system due to non emergent Alcohol or Drug disorder (and frequently, comorbid other mental health conditions). The Sobering Center offers an alternative that saves health care system costs. The individual will remain at the Sobering Center until they are sober enough to safely return to the community. Prior to discharge from the center, every individual will be offered alcohol and/or drug treatment options tailored to their specific needs and followed up to ensure appropriate utilization of care according to protocol.

Data Source: Program Data System

Project Milestones:
- DY2: [P-X1]: Development of Outreach and Education Plan to Target population
- DY 3
  - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve
  - P-5: Milestone: Disseminate lessons learned and best practices

Outcome Improvement Target(s) for each year:
- DY 4:
  - IT-9.4 Other Outcome Improvement Target
    - Reduce rate of all ER visits or hospitalization related to intoxication or substance use that are non emergent by 2% over baseline among program participants during a 6 month period
- DY 5:
  - IT-9.4 Other Outcome Improvement target
    - Reduce rate of all ER visits or hospitalization related to intoxication or substance use that are non emergent by 4% over baseline among program participants during a 6 month period.

Rationale:
We chose our outcome measure from outcome domain “Right Setting Right Care” under Other Outcome Improvement target. We will be measuring preventable admissions to ER/hospitals/criminal justice setting due to non-emergent alcohol/other substance use intoxication as our outcome indicator. Frequent visits to the emergency room is an indicator of alcohol or drug disorders and mental illness, according to a report by DSHS Research and Data Analysis Division in Washington State. This study reports that 55 percent of clients who visited the ER 21 times or more in Fiscal Year (FY) 2002 had diagnoses of both an Alcohol or Drug

Regional Healthcare Partnership Plan Region 3 1764
AOD disorder and mental illness. An additional 7 percent of the most frequent ER visitors had an AOD disorder only and 23 percent had a mental illness only. Only 15 percent of the most frequent ER visitors had no indication of an AOD disorder or mental illness. Few Frequent Emergency Room Visitors With Alcohol Or Drug Disorders Receive AOD Treatment [www.dshs.wa.gov/pdf/ms/rdaresearch/11/119-31.pdf].

The Sobering Center will provide a cost-effective alternative to using ER/hospitals/criminal justice settings for non-emergent AOD disorders (frequently with comorbidity such as mental illness), at no cost to the patient. Other cities adopting such sobering centers have seen reductions in arrests and jail time for these offenders, as well as fewer emergency room and hospital check-ins for this often indigent population, on top of the cost savings found in jail bed diversions. This approach is more effective because it addresses the underlying issue of alcohol and or other substance abuse inherent in most public intoxication offenses. A 2003 study on the Impact of the San Diego Serial Inebriate Program on Use of Emergency Resources concluded that the program reduced the use of EMS, Emergency Department and inpatient resources by individuals who were repeatedly intoxicated in public. By using patient care navigators and assisting patients to get appropriate care and referrals as necessary, there is less of a burden on the health care system.

Outcome Valuation

The Outcome measure was valued at 9.04% of the overall assigned project value for the associated Category 2 project in year 3, 9.04% in Year 4 and 9.04% in Year 5. HHDHS utilized the following method to determine the Category 2 project value. HHDHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HHDHS Valuation Tool). HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs, 4) Cost Avoidance, 5) Partnership Collaboration, and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a predetermined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HHDHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HHDHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The Care Houston Links Program received a composite Prioritization score of 5.35 and a Public Health Impact score of 6.
References:
http://www.rightoncrime.com/2012/05/sobering-centers-cutting-jail-populations-costs-and-crime/
|---------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| [P-X1]: Development of Outreach and Education Plan to Target population | Metric: Written report on Outreach Education Plan for Service Linkage Program  
Goal: To disseminate information about Sobering Center program in Target Population  
Data Source: Program Documentation | Process Milestone 2 [P-4]: Conduct Plan Do Study Act cycle to continually improve  
Metric: Document use of PDSA in planning process  
Goal: development of report documenting use of PDSA in planning process  
Data Source: Report documentation | Outcome Improvement Target 1 [IT-9.4]: Decrease in preventable admissions to ER/hospitals/criminal justice setting due to non-emergent alcohol/other substance use intoxication in a 6 month period  
Goal: Decrease admission and readmission to ER and hospitals and criminal justice settings by 2% over baseline. (Baseline TBD in DY 3)  
Numerator: The number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to an ER or hospital facility or to the criminal justice system within the measurement period (every 6 months)  
Denominator: The number of individuals receiving project intervention(s)  
Data Sources: criminal justice system records, Program records | Outcome Improvement Target 2 [IT-9.4]: Decrease in preventable admissions to ER/hospitals/criminal justice settings due to non-emergent alcohol/other substance use intoxication in a 6 month period  
Goal: Decrease admission and readmission to ER and hospitals and criminal justice settings by 4% over baseline.  
Numerator: The number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to an ER or hospital facility or to the criminal justice system within the measurement period (every 6 months)  
Denominator: The number of individuals receiving project intervention(s)  
Data Sources: criminal justice system records, Program records |
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: $91,637.89</td>
<td>Year 3 Estimated Outcome Amount: $214,412.12</td>
<td>Year 4 Estimated Outcome Amount: $228,251.32</td>
<td>Year 5 Estimated Outcome Amount: $496,316.43</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $1,030,617.77
Project Option 2.6.4 - Implement other evidence based project to implement health promotion programs in an innovative manner not described above.

Unique Project ID: 0937740-08.2.7

Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

Intervention(s): The performing provider will implement interventions to provide an expansion of an evidence-based home visitation program for 100 first time mothers in an underserved area. This consists of 64 home visits over two and one half years for each client enrolled in the program with visits conducted weekly, bi-monthly and monthly.

Need for the Project: This expansion project provides a comprehensive evidence based care to underserved enrolled clients. Underserved clients would not normally have access to comprehensive services provided by such a program to improve birth outcomes for the child and health and social outcomes for the mother. Last year, the NFP served 146 clients with the home visitation program of which 66% were Medicaid clients. Two thirds of the women served by this NFP expansion are expected to be Medicaid recipients.

Target Population: The target population will be women who live in a geographically identified area of the city who have high rates of low birth weights and low prenatal care rates. Recruitment for the program will be conducted from the performing provider’s health clinics and WIC Centers.

Category 1 or 2 expected patient benefits: Increase the number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model by 5% over baseline in DY4 and by 10% over baseline in DY5. During DY3, 100 first time mothers will be served over two and a half years. In DY 4, the number of women served will increase to 105 to account for attrition and in DY 5, 110 mothers will be served, again accounting for attrition over the course of the program.

Category 3 outcomes: IT-8.2 Percentage of low birth weight babies - Reduce percentage of Low Birth- weight births by 2% in DY4 and by 4% in DY5 among women enrolled in the program.
IT-8.1 Timeliness of Prenatal Care - Increase by 5% over baseline number of women that receive recommended prenatal and postnatal care in DY4 and by 10% over baseline in DY5.

**Title of Outcome Measure (Improvement Target):** IT-8.2 Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)263 (*Standalone measure*)

**Unique RHP Outcome identification number(s):** 0937740-08.3.11

**Performing Provider Name/TPI:** City of Houston Department of Health and Human Services/0937740-08

**Outcome Measure Description:**

IT-8.2 Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)263 (*Standalone measure*)

- **Numerator:** The number of babies born weighing <2,500 grams at birth enrolled in NFP program
- **Denominator:** All births of women enrolled in NFP program

**Process Milestones:**

- **DY2:**
  - P – 2: Establish Baseline
  - P-3: Develop and test Data systems
  - P – 1: Project Planning

- **DY 3:**
  - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve
    - Metric: Document use of PDSA in planning process
  - P-5: Milestone: Disseminate lessons learned and best practices
    - Metric 1: Documentation of best practices and lessons learned

**Outcome Improvement Targets for each year:**

- **DY 4:**
  - IT-8.2 Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)263 (*Standalone measure*)
    - Reduce Low Birth Weight Births by 2% over baseline

- **DY 5:**
  - IT-8.2 Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)263 (*Standalone measure*)
    - Reduce Low Birth Weight Births by additional 4% over baseline

**Rationale:**

The outcome measure selected for this program was Percentage of Low Birth Weight Births. This outcome was selected because:

- Pre-term birth is defined as babies born alive before 37 weeks of pregnancy is completed. Being born too soon places the life of the baby in a precarious position. According to the World Health Organization, pre-term birth is the leading cause of newborn deaths (death during the first 4 weeks of life) and the second leading cause of death in children under the age of five. Many cost effective strategies have been identified to reduce pre-term birth and produce better birth outcomes such as home visitation programs and other interventions.

- Nurse Family Partnership is one such evidence based home visitation program that has demonstrated better birth outcomes and better outcomes for the new mother by providing care.
before, during and after pregnancy. According to the Nurse Family Partnership website, data from the 1990 Nurse Family Partnership (NFP) Memphis trial noted that the NFP nurse-visited families gained academic and employment skills to become economically self-sufficient. According to this analysis, NFP services resulted in lower enrollment in Medicaid and Food Stamps, with a 9% reduction in Medicaid costs and an 11% reduction in Food Stamps costs in the 10 years following the birth of the child. Federal savings were estimated at 154% of costs, yielding a net 54% return on the federal investment.

**Outcome Measure Valuation:**
The Outcome measure was valued at 11.75% of the overall assigned project value for the associated Category 2 project in year 3, 11.75% in Year 4 and 11.75% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HHDHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HHDHS Valuation Tool). HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4) Cost Avoidance 5) Partnership Collaboration and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a predetermined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HHDHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a predetermined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HHDHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. NFP received a composite Prioritization score of 6.95 and a Public Health Impact score of 7.
### Related Category 1 or 2 Projects:

#### Starting Point/Baseline:

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P – 2]: Establish Baseline</strong>&lt;br&gt;<strong>Metric 1:</strong> Current rates for low birth weight in Sunnyside&lt;br&gt;<strong>Metric 2:</strong> Current rates for infant mortality in Sunnyside&lt;br&gt;Baseline: Establish baseline metrics&lt;br&gt;Data Source: Vital Statistics data</td>
<td><strong>Process Milestone 4 [P-4]: Conduct Plan Do Study Act cycle to continually improve</strong>&lt;br&gt;<strong>Metric 1:</strong> Document use of PDSA in planning process&lt;br&gt;Goal: Use a cyclical PDSA process and implementation improvement strategy&lt;br&gt;Data Source: Program Documentation</td>
<td><strong>Outcome Improvement Target 1 [IT-8.2]: IT-8.2 Percentage of Low Birth-weight births (CHIPRA/NQF # 1382)263 (Standalone measure)</strong>&lt;br&gt;Improvement Target: Reduce low birth weight birth rate by 2% from Baseline numbers in program participants. Baseline will be determined in DY 3.&lt;br&gt;Data Source: Medical Record/other&lt;br&gt;Numerator: The number of babies born weighing &lt;2,500 grams at birth among program participants&lt;br&gt;Denominator: All births among program participants.&lt;br&gt;Data source: Electronic Records</td>
<td><strong>Outcome Improvement Target 2 [IT-8.2]: IT-8.2 Percentage of Low Birth-weight births (CHIPRA/NQF # 1382)263 (Standalone measure)</strong>&lt;br&gt;Improvement Target: Reduce low birth weight birth rate by 4% from Baseline in program participants.&lt;br&gt;Data Source: Medical Record/other&lt;br&gt;Numerator: The number of babies born weighing &lt;2,500 grams at birth among program participants&lt;br&gt;Denominator: All births among program participants.&lt;br&gt;Data source: Electronic Records</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $19,847.89</td>
<td>Process Milestone 4 Estimated Incentive Payment: $69,659.41</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $148,311.12</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $322,492.10</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]: Develop and test Data systems</strong>&lt;br&gt;<strong>Metric 1:</strong> Documentation of discussions of partnership with of established national data system&lt;br&gt;<strong>Metric 2:</strong> Documentation of established partnership with national data system&lt;br&gt;Goal: Implement user friendly data system that can ease reporting of program participation and outcomes.&lt;br&gt;Data Source: Data systems</td>
<td><strong>Process Milestone 5 [P-5]: Disseminate lessons learned and best practices</strong>&lt;br&gt;<strong>Metric 1:</strong> Documentation of best practices and lessons learned. Goal: Share best practices and lessons learned with community partners.&lt;br&gt;Data Source: Program Documents</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $148,311.12</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $19,847.89</td>
<td>Process Milestone 5 Estimated Incentive Payment: $69,659.41</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3 [P – 1]: Project Planning</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Percentage of Low Birth-weight births (CHIPRA/NQF # 1382)263 (Standalone measure)

**RHP Performing Name:** City of Houston Health and Human Services

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>[RHP Performing Provider - 0937740-08]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>0937740-08.2.7</td>
</tr>
</tbody>
</table>

#### Year 2 (10/1/2012 – 9/30/2013)
- **Metric 1:** Documentation of project plan, capacity, scope, and timeline
- **Goal:** Complete all planning steps to ensure successful implementation of program.
- **Data Source:** Program documentation
- **Process Milestone 3 Estimated Incentive Payment:** $19,847.89

#### Year 3 (10/1/2013 – 9/30/2014)

#### Year 4 (10/1/2014 – 9/30/2015)

#### Year 5 (10/1/2015 – 9/30/2016)

**Year 2 Estimated Outcome Amount:** $59,543.66

**Year 3 Estimated Outcome Amount:** $139,318.81

**Year 4 Estimated Outcome Amount:** $148,311.1

**Year 5 Estimated Outcome Amount:** $322,492.10

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $669,665.68*
Project Option 2.6.4 - Implement other evidence based project to implement health promotion programs in an innovative manner not described above.

Unique Project ID: 0937740-08.2.7

Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

Intervention(s): The performing provider will implement interventions to provide an expansion of an evidence-based home visitation program for 100 first time mothers in an underserved area. This consists of 64 home visits over two and one half years for each client enrolled in the program with visits conducted weekly, bi-monthly and monthly.

Need for the Project: This expansion project provides a comprehensive evidence based care to underserved enrolled clients. Underserved clients would not normally have access to comprehensive services provided by such a program to improve birth outcomes for the child and health and social outcomes for the mother. Last year, the NFP served 146 clients with the home visitation program of which 66% were Medicaid clients. Two thirds of the women served by this NFP expansion are expected to be Medicaid recipients.

Target Population: The target population will be women who live in a geographically identified area of the city who have high rates of low birth weights and low prenatal care rates. Recruitment for the program will be conducted from the performing provider’s health clinics and WIC Centers.

Category 1 or 2 expected patient benefits: Increase the number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model by 5% over baseline in DY4 and by 10% over baseline in DY5. During DY3, 100 first time mothers will be served over two and a half years. In DY 4, the number of women served will increase to 105 to account for attrition and in DY 5, 110 mothers will be served, again accounting for attrition over the course of the program.

Category 3 outcomes: IT-8.2 Percentage of low birth weight babies - Reduce percentage of Low Birth- weight births by 2% in DY4 and by 4% in DY5 among women enrolled in the program.
IT-8.1 Timeliness of Prenatal Care - Increase by 5% over baseline number of women that receive recommended prenatal and postnatal care in DY4 and by 10% over baseline in DY5.

**Title of Outcome Measure (Improvement Target):** IT-8.1 Timeliness of Prenatal/Postnatal Care45 (CHIPRA Core Measure/NQF #1517)

**Unique RHP Outcome identification number(s):** 0937740-08.3.12

**Performing Provider Name/TPI:** City of Houston Department of Health and Human Services/0937740-08

**Outcome Measure Description:**
IT-8.1 Prenatal/Postnatal Care45 (CHIPRA Core Measure/NQF #1517) (Non-standalone measure)

Numerator: Deliveries of live births for which women receive the following facets of prenatal and postpartum care: Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

Denominator: Deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year

**Process Milestones:**
- **DY2:**
  - P – 2: Establish Baseline
  - P-3: Develop and test Data systems
  - P – 1: Project Planning
- **DY 3**
  - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve
    - Metric: Document use of PDSA in planning process
  - P-5: Milestone: Disseminate lessons learned and best practices
    - Metric 1: Documentation of best practices and lessons learned

**Outcome Improvement Targets for each year:**
- **DY 4:**
  - IT-8.1 Timeliness of Prenatal/Postnatal Care262 (CHIPRA Core Measure/NQF #1517) (Non-standalone measure)
    - Increase the percentage of women receiving timely prenatal and postnatal care by 5% over baseline
  - IT-8.1 Timeliness of Prenatal/Postnatal Care262 (CHIPRA Core Measure/NQF #1517) (Non-standalone measure)
    - Increase the percentage of women receiving timely prenatal and postnatal care by 10% over baseline

**Rationale:**
The outcome measures selected for this program was Timeliness of Prenatal Care. This outcome was selected because:

Provision of timely and adequate recommended prenatal care is extremely important to improve birth outcomes in low-income women who may typically not have access to regular
primary and preventive care. Prenatal care given starting the first 3 months of pregnancy can have an impact on the health of the baby as well as the mother. Access to early prenatal care by allowing women and providers to identify and address health problems and behaviors that may cause particular harm during early fetal development, first-trimester prenatal care can lead to improved outcomes, according to the US Department of Health and Human Services. Early prenatal care is likely to matter most for women who are at elevated risk of poor birth outcomes due to smoking, poor nutritional status, HIV-positive status, or other serious health problems prior to pregnancy.

Extensive evaluation of the NFP program indicates that it is predictive of better birth outcomes, including fewer pre-term births. According to the Nurse Family Partnership website, data from the 1990 Nurse Family Partnership (NFP) Memphis trial noted that the NFP nurse-visited families gained academic and employment skills to become economically self-sufficient. According to this analysis, NFP services resulted in lower enrollment in Medicaid and Food Stamps, with a 9% reduction in Medicaid costs and an 11% reduction in Food Stamps costs in the 10 years following the birth of the child. Federal savings were estimated at 154% of costs, yielding a net 54% return on the federal investment.

**Outcome Measure Valuation:**

The Outcome measure was valued at 11.75% of the overall assigned project value for the associated Category 2 project in year 3, 11.75% in Year 4 and 11.75% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HHDHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HHDHS Valuation Tool). HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs, 4) Cost Avoidance, 5) Partnership Collaboration, and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HHDHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2)
Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. NFP received a composite Prioritization score of 6.95 and a Public Health Impact score of 7.
**RHP Performing Name:** City of Houston Health and Human Services

**Starting Point/Baseline:** Established in DY 2-3

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

### Process Milestone 1 [P – 2]: Establish Baseline

**Metric 1:** Current rates for prenatal care in Sunnyside

Baseline: Establish overall baseline metrics for area
Data Source: Vital Statistics data

Process Milestone 1 Estimated Incentive Payment: $19,847.89

### Process Milestone 2 [P-3]: Develop and test Data systems

**Metric 1:** Documentation of discussions of partnership with of established

### Process Milestone 3 [P-4]: Conduct Plan Do Study Act cycle to continually improve

**Metric 1:** Document use of PDSA in planning process
Goal: Use a cyclical PDSA process and implementation improvement strategy
Data Source: Program Documents

Process Milestone 4 Estimated Incentive Payment: $69,659.41

### Process Milestone 5 [P-5]: Disseminate lessons learned and best practices

**Metric 1:** Documentation of best practices and lessons learned.
Goal: Share best practices and lessons learned with community
Data Source: Program Documents

**Outcome Improvement Target 1**

**[IT-8.1]:** Timeliness of Prenatal/Postnatal Care45 (CHIPRA Core Measure/NQF #1517) (Non-standalone measure)

Improvement Target: Increase by 10% over baseline number of women that receive recommended prenatal and postnatal care.

Data Source: Electronic Records

Numerator: Deliveries of live births among women enrolled in the program for which women receive the following facets of prenatal and postpartum care:

Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

Denominator: Deliveries of live births

**Outcome Improvement Target 2**

**[IT-8.1]:** Timeliness of Prenatal/Postnatal Care45 (CHIPRA Core Measure/NQF #1517) (Non-standalone measure)

Improvement Target: Increase by 5% over baseline number of women that receive recommended prenatal and postnatal care.

Data Source: Electronic Records

Numerator: Deliveries of live births among women enrolled in the program for which women receive the following facets of prenatal and postpartum care:

Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

Denominator: Deliveries of live births
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects::</td>
<td>0937740-08.2.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Established in DY 2-3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Implement user friendly data system that can ease reporting of program participation and outcomes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Data systems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $19,847.89</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National data system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 2: Documentation of established partnership with national data system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Complete all planning steps to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>lessons learned with community partners.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 5 Estimated Incentive Payment: $69,659.41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $148,311.12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 [P – 1]: Project Planning Milestone– Identify and engage partners, establish current capacity and needed resources and timeline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1: Documentation of project plan, capacity, scope, and timeline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Complete all planning steps to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>enrollment in the organization.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: Deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year in women enrolled in program care.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Program Baseline will be established in DY 2-3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $322,492.10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Ensure successful implementation of program.</td>
<td>Data Source: Program documentation</td>
<td>Process Milestone 3 Estimated Incentive Payment: $19,847.89</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $59,543.66</td>
<td>Year 3 Estimated Outcome Amount: $139,318.81</td>
<td>Year 4 Estimated Outcome Amount: $148,311.12</td>
<td>Year 5 Estimated Outcome Amount: $322,492.10</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYS 2-5): $669,665.68*
City of Houston Department of Health and Human Services

Pass 2
Project Option 2.19.2 - Develop Care Management Function that integrates primary and behavioral health needs of individuals

Unique Project ID: 0937740-08.2.8

Performing Provider Name/TPI: Houston Department of Health and Human Services/0937740-08

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas with a population of 2.1 million in 2010. HDHHS has 1,100 employees and a budget of $100,245,403. HDHHS serves the City of Houston through 44 distinct programs. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring and restaurant inspections; birth and death certificates; leadership in emergencies such as hurricanes; operates a comprehensive regional reference laboratory, provides communicable disease prevention and control services and disease surveillance and a variety of health and human services such as the Women, Infants and Children (WIC) nutrition program, senior nutrition services, family planning, oral health services and immunizations via a network of 4 health centers, 14 WIC sites and the Harris County Area Agency on Aging.

Intervention(s): This new Homeless project will serve 200 individuals who are chronically homeless and offer comprehensive service integration intervention. This project will implement its comprehensive five step intervention for the homeless involving 1) permanent housing supportive model 2) program service linkages 3) physical and behavioral health needs 4) financial support 5) other services.

Need for the Project: There is a great need for an integrated system of care for the homeless (defined as four or more bouts of homelessness in the past 3 years or more than a year of current consecutive homelessness) that will effectively house and provide supportive services. This project provides a comprehensive evidence based care to chronically homeless clients who have an ongoing need for housing, physical and behavioral health services. There are at least 2000 chronically homeless individuals in Houston according to the last count performed by the Homeless Coalition. People experiencing chronic homelessness have the following characteristics: 1) typically male (79-86%) and middle age (60% are 35-54), 2) 63% unsheltered, 3) almost 100% with presence of disabilities & frequently multiple disabilities at once and 4) frequently use emergency rooms, hospitals, mental health services, veterans’ services, substance abuse detoxification and treatment, and criminal justice resources. (Chronic Homelessness Policy Solutions, Chronic Homelessness Brief March 2010, National Alliance to End Homelessness).

Target Population: The project targets individuals with histories of mental illness, addiction, complicated medical problems and meet HUD’s definition of chronic homelessness and frequent users of hospitals and crises response systems.

Category 1 or 2 expected patient benefits: Increase patient/target population utilization rates of each aspect of program (Housing, program services, physical and behavioral needs, financial services and other services) by 2% over baseline in DY4 and by 5% over baseline in DY5. During DY3 a baseline of 175 individuals will be placed in permanent housing; in DY4, the
number of people in permanent housing will increase to 184, and in DY5 the number in permanent housing will increase to 193.

**Category 3 outcomes: IT-9.4 Other Outcome Improvement Target - Reduce non emergent ED usage in program participants by 5% over baseline in DY4 and by 10% in DY 5.**

**Title of Outcome Measure (Improvement Target):** IT-9.4 Other Outcome Improvement Target (Right Care, Right Setting)

**Unique RHP Outcome identification number(s):** 0937740-08.3.12

**Performing Provider Name/TPI:** City of Houston Department of Health and Human Services/0937740-08

**Outcome Measure Description:**
IT-9.4 Other Outcome Improvement Target (Right Care Right Setting) – Reduce ER use in homeless population enrolled in program
Numerador: Number of non-emergent ED visits for target population served by the program in past 12 months
Denominator: Total number of target population served by the program in past 12 months

**Process Milestones:**
- **DY2:**
  - [P-7] Needs Assessment to determine number and types of needs of the target population
- **DY 3:**
  - P-4 Metric: Conduct Plan-Do-Study-Act
  - P-5 Milestone: Disseminate findings, lessons learned and best practices

**Outcome Improvement Targets for each year:**
- **DY 4:**
  - **IT-9.4 Other Outcome Improvement Target**
  - Metric: Reduce non emergent ED usage in program participants by 5% over baseline
- **DY 5:**
  - **IT-9.4 Other Outcome Improvement Target**
  - Metric: Reduce non emergent ED usage in program participants by 10% over baseline

**Rationale:**
The outcome measure chosen for this project under Outcome Domain “Right Setting Right Care” is “Other Outcome Improvement Target. We anticipate that comprehensive navigation and care management will reduce the number of homeless program participants that end up in ER due to any number of comorbidities. This program plans to provide housing, program services, physical
and behavioral health services, financial services and other services (peer trainers etc.) to homeless individuals enrolled in the program. Provision of this type of an integrated service to this indigent group with special needs along with follow-up will improve physical and behavioral health outcomes as well as address their acute housing needs.

**Outcome Measure Valuation:**
The Outcome measure was valued at 11.67% of the overall assigned project value for the associated Category 2 project in year 3, 11.67% in Year 4 and 11.67% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HHDHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HHDHS Valuation Tool). Consistent with other participants in the regional partnership, HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4) Cost Avoidance 5) Partnership Collaboration and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HHDHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HHDHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. Integrated services for the homeless received a composite Prioritization score of 10 and a Public Health Impact score of 10.

Reference

**Performing Provider Name:** City of Houston Health and Human Services  
**HDHHS -0937740-08**

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Unique Category 2 Identifier - 0937740-08.2.8</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>TBD in DY3</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1 [P-7]:** Needs Assessment to determine number and types of needs of the target population  
Metric: Needs assessment conducted  
Goal: Develop program to match needs of the target population  
Data Source: Program needs assessment and data documentation  
Milestone 1 Estimated Incentive Payment: $127,446

**Process Milestone 2 [P-4]:** Conduct Plan Do Study Act cycle to continually improve  
Metric: Document use of PDSA in planning process  
Goal: Utilize a cyclical quality improvement process  
Data Source: Program Documentation  
Milestone 2 Estimated Incentive Payment: $150,980.79

**Process Milestone 3 [P-5]:** Disseminate lessons learned and best practices  
Metric: Documentation of best practices and lessons learned  
Goal: Share lessons learned  
Data Source: program Documentation  
Milestone 3 Estimated

**Other Outcome Improvement Target 1: IT-9.4 Other Outcome Improvement Target**  
Metric: Reduce non emergent ED usage in program participants  
Numerator: Number of non-emergent ED visits for target population served by the program in past 12 months  
Denominator: Total number of target population served by the program in past 12 months  
Goal: Decrease non emergent ED visits by 5% over baseline (will be established in DY 3)  
Data Source: Program Data and Follow-up data  
Milestone 4 Estimated Incentive Payment: $326,765

**Other Outcome Improvement Target 2: IT-9.4 Other Outcome Improvement Target**  
Metric: Reduce non emergent ED usage in program participants  
Numerator: Number of non-emergent ED visits for target population served by the program in past 12 months  
Denominator: Total number of target population served by the program in past 12 months  
Goal: Decrease non emergent ED visits by 10% over baseline (will be established in DY 3)  
Data Source: Program Data and Follow-up data  
Milestone 5 Estimated Incentive Payment: $707,844
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Incentive Payment:** $150,980.79

**Year 2 Estimated Outcome Amount:** $127,446.34

**Year 3 Estimated Outcome Amount:** $301,961.59

**Year 4 Estimated Outcome Amount:** $326,764.77

**Year 5 Estimated Outcome Amount:** $707,843.61

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $1,464,016
Project Option 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.)

Unique Project ID: 0937740-08.2.9

Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Summary: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs.

Intervention(s): The interventions for this new colorectal cancer (CRC) integrated awareness and screening (COCAS) project are to provide CRC FIT screening for 320 new individuals in DY4 and 460 new individuals in DY5, for the two target geographic areas combined; in twelve spatially identified, primarily African American, high risk zip codes. It will involve: 1) Awareness raising small media campaign utilizing culturally appropriate messages, 2) CRC Education about Screening Guidelines and Recommendations, 3) Access to Community wide Non-invasive FIT testing, 4) Test taking training, 5) Testing by nationally accredited laboratory, 6) Sharing of test results, communication and Follow up protocol as appropriate, and 7) Patient Care Navigation for getting individuals situated in a medical home in the targeted zip codes. The total number of individuals reached by COCAS through the integrated project in two target areas will be 800 in Baseline DY3, 840 in DY 4 and 856 in DY5.

Need for the Project: Screening for CRC can test for disease in early stages before symptoms occur. This can prevent morbidity and mortality due to CRC. Significant disparities exist in CRC outcomes with low income, minorities having the poorest outcomes. Screening rates for CRC by a population level, non-invasive method (FOBT) is low in Harris County. This project aims to increase screening rates through a comprehensive program in high risk zip codes.

Target Population: The target population for this project are 50-75 year old men and women (in keeping with the screening guidelines) in twelve high risk zip codes (with previously identified age adjusted spatial clusters of late stage CRC diagnosis) indicating lack of timely screening.

Category 1 or 2 expected patient benefits: Increase number of patients in defined population receiving innovative intervention consistent with evidence-based model by 60% over baseline in DY4 and by 80% over baseline in DY5. The number of new individuals reached by the integrated intervention are 800 in DY3 and 840 in DY4 and 856 in DY5. Of these, 200 will receive FIT screening in DY3 and 320 in DY4 and 460 in DY5.
Category 3 outcomes: IT-6.1 Percent improvement over baseline of patient satisfaction scores (Patients are getting timely care, appointments, and information). – Standalone measure. The integrated COCAS project is expected to increase patient satisfaction scores due to its focus on bridging patient, system and provider related barriers.

**Title of Outcome Measure (Improvement Target):** Colorectal Cancer Screening Patient Satisfaction Scores

**Unique RHP Outcome identification number(s):** 0937740-08.3.13

**Performing Provider/TPI:** City of Houston Department of Health and Human Services/0937740-08.2.8

**Outcome Measure Description:** IT-6.1 Percent improvement over baseline of patient satisfaction scores (Patients are getting timely care, appointments, and information). – **Standalone**

Factors related to patient, providers and the system contribute to poor screening rates. Patient satisfaction scores can potentially increase by including effective patient-level interventions by reducing structural barriers (e.g., direct mailing/pick up of FOBT kits), one-on-one interaction with a healthcare provider or health educator, and patient reminders (e.g., telephone calls, postcards). For some other patient-level interventions, such as group education and organized approaches to screening dramatically increased colorectal cancer screening rates. In addition, some studies have documented the effectiveness of patient navigators (or similar approaches) when used as part of a healthcare system’s intervention. The integrated COCAS project is expected to increase patient satisfaction scores due to its focus on bridging patient, system and provider related barriers. The COCAS intervention consists of all of the above domains and therefore, patient satisfaction scores are expected to be enhanced by the COCAS Program.

Numerator: Percent improvement in targeted patient satisfaction domain

Denominator: Number of patients who were administered the survey

**Process Milestones:**

- **DY 2**
  - P-3: Develop and test data system

- **DY3:**
  - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve program
  - P-5: Milestone: Disseminate lessons learned and best practices
Outcome improvement targets for each year:

- DY 4:
  - IT-6.1 Percent improvement of 2% over baseline of patient satisfaction scores

- DY 5:
  - IT-6.1 Percent improvement of 5% over baseline of patient satisfaction scores

Rationale:

Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden. An integrated program such as COCAS can bridge some of the patient, provider and system level barriers that are known to be reasons for low screening rates.

Outcome Measure Valuation:

The Outcome measure was valued at 18.63% of the overall assigned project value for the associated Category 2 project in year 3, 18.63% in Year 4 and 18.63% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HHDHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4) Cost Avoidance 5) Partnership Collaboration and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a pre-
determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 50% and the Public Health Impact score a weight of 50% to determine the overall project value for the plan. CRC received a composite Prioritization score of 2.29 and a Public Health Impact score of 2.29.

Reference

### Unique Category 3 ID:
0937740-08.3.13

### Ref Number from RHP PP
IT-6.1

### IT-6.1 Percent improvement over baseline of patient satisfaction scores

### RHP Performing Provider involved with this project - Name
City of Houston Health and Human Services

### TPI - 0937740-08

### Related Category 1 or 2 Projects::
Unique Cat 1 ID: 0937740-08.2.8

### Starting Point/Baseline:
Project Baseline will be established in DY 2-3

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P- 2] Develop and test data system in DY2 months 6-12</td>
<td>Process Milestone2 [P-4]: Conduct Plan Do Study Act cycle to continually improve</td>
<td>Outcome Improvement Target 1 IT-6.1 Percent improvement over baseline of patient satisfaction scores (Patients are getting timely care, appointments, and information). –Standalone</td>
<td>Outcome Improvement Target 2 IT-6.1 Percent improvement over baseline of patient satisfaction scores (Patients are getting timely care, appointments, and information). –Standalone</td>
</tr>
<tr>
<td>Metric: Documentation of testing and selection of data system</td>
<td>Metric: Document use of PDSA in planning process</td>
<td>Numerator: Percent improvement in targeted patient satisfaction domain</td>
<td>Numerator: Percent improvement in targeted patient satisfaction domain</td>
</tr>
<tr>
<td>Goals: Establish efficient data system that can track program outcomes.</td>
<td>Goal: Goal: Ensure highest quality on program process and improvement.</td>
<td>Denominator: Number of patients who were administered the survey</td>
<td>Denominator: Number of patients who were administered the survey</td>
</tr>
<tr>
<td>Data Sources: Program documentation from month 6-12 inDY2</td>
<td>Data Source: Step-wise documentation of PDSA in program documentation</td>
<td>Data Source: Participant and program scores documentation</td>
<td>Data Source: Participant and program scores documentation</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $29,185</td>
<td>Milestone 3 [P-5]: Disseminate lessons learned and best practices</td>
<td>Goal: Increase by 2% over baseline (Baseline to be established in DY 2-3)</td>
<td>Goal: Increase by 5% over baseline (Baseline to be established in DY 2-3)</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment:</td>
<td></td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment:</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment:</td>
</tr>
<tr>
<td>Year</td>
<td>Metric 1</td>
<td>Metric 2</td>
<td>Goal</td>
</tr>
<tr>
<td>------</td>
<td>----------</td>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td>2</td>
<td>Documentation of best practices</td>
<td>Documentation of lessons learned</td>
<td>Provide report documenting identification of best practices and lessons learned</td>
</tr>
<tr>
<td>3</td>
<td>$74,829.14</td>
<td>$162,096.18</td>
<td>$29,185</td>
</tr>
<tr>
<td>4</td>
<td>$74,829.14</td>
<td>$162,096.18</td>
<td>$69,149.20</td>
</tr>
<tr>
<td>5</td>
<td>$162,096.18</td>
<td>$162,096.18</td>
<td>$74,829.14</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5: $335,259)
City of Houston Department of Health and Human Services
Pass 3
Project Option - 1.8.11 The implementation of dental services for individuals in long-term care facilities, intermediate care facilities, and nursing homes, and for the elderly, and/or those with special needs by enhancing dental workforce capacity through collaborations and partnerships with dental and dental hygiene schools, LHDs, FQHCs, and/or local dental providers

**Unique Project ID:** 0937740-08.1.3

**Performing Provider Name/TPI:** City of Houston Department of Health and Human Services/0937740-08

**Project Summary:** Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 4 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

**Intervention(s):** This new project will improve oral health by providing diagnostic, preventive, restorative, and surgical oral health services for the elderly to improve the health and quality of life for Houston area at-risk seniors. Training the next public health work force is also a goal of the program. 4th year dental students from the University of Texas School of Dentistry (UTSD), dental hygiene students from UTSD, and dental hygiene students from Houston Community College (HCC) will be trained to provide dental care for the seniors within one of the HDHHS safety net dental clinics.

**Need for the Project:** By 2040, the number of US seniors, over the age of 65, is expected to double to 71 million. By 2030, the number of seniors, over the age of 85, is expected to be 9.6 million. As the US seniors live longer, many will be retaining their teeth and many will experience co-morbidities. Older persons who live below the poverty line were almost three (3) times as likely to report unmet dental needs as those who live at or above the poverty line (11 and 4 percent, respectively).

**Target Population:** The primary target population will be at risk low income or indigent seniors seen at public clinics and FQHC’s. More than 80% of the target population is usually low income or indigent in these clinic settings.

**Category 1 or 2 expected patient benefits:** [I-14] Increase by 5% over baseline of special population members that access dental services in DY4 and by 10% over baseline in DY5. In DY3, 60 indigent oral health patients will be served, in DY4, 63 indigent patients will be served and in DY5, 66 oral health patients will be served.
Category 3 outcomes: IT-7.8: Increase by 5% over baseline percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider in DY4 and by 10% over baseline in DY 5.

**Title of Outcome Measure (Improvement Target):** IT-7.8 Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider

**Unique RHP Outcome identification number(s):** 0937740-08.3.15

**Performing Provider/TPI:** City of Houston Department of Health and Human Services/0937740-08

**Outcome Measure Description:**
IT-7.8 Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider (*Standalone measure*). Older adults with comorbid conditions have to be treated for poor oral health but care also needs to be coordinated and synchronized with other providers that are treating the patient.

**Process Milestones :**
- DY 2
  - Develop and test data systems
- DY3:
  - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve program
  - P-5: Milestone: Disseminate lessons learned and best practices

**Outcome improvement targets for each year:**
- DY 4:
  - IT-7.8 Chronic Disease Patients Accessing Dental Services: Increase by 5% over baseline percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider
- DY 5
  - IT-7.8 Chronic Disease Patients Accessing Dental Services: Increase by 10% over baseline percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider

**Rationale:**
The process milestones P4 and P5 were chosen for this project based on the need for documentation of baseline and continuous quality improvements in program for reduction of dental caries. The PDSA cycle will inform systematic data driven program improvements. Inadequate access to dental services compounds other health issues. Chronic diseases and oral diseases share many common risk factors.

Poor oral health can result in untreated dental disease that not only affects the mouth, but can also have physical, mental, economic and social consequences. Severe gum disease is associated with chronic disease and severe health conditions such as diabetes, heart disease, stroke and respiratory disease. Fortunately, many of the adverse effects associated with poor oral health can be prevented with quality on-going dental care, both at home and professionally.
Increasing, expanding, and enhancing dental services will improve overall health outcomes in the elderly.

**Outcome Measure Valuation:**
The Outcome measure was valued at 15.82% of the overall assigned project value for the associated Category 2 project in year 3, 15.82% in Year 4 and 15.82% in Year 5. HHDHS utilized the following method to determine the Category 2 project value. The HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs, 4) Cost Avoidance, 5) Partnership Collaboration and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a predetermined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDDHS gave the Prioritization score a weight of 50% and the Public Health Impact score a weight of 50% to determine the overall project value for the plan. Geriatric Oral Health received a composite Prioritization score of 1.88 and a Public Health Impact score of 1.88.
Chronic Disease patients accessing oral health services

<table>
<thead>
<tr>
<th>Process Milestone 1 [P- 3] Develop and test data systems</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1:</strong> Select, install and test data system</td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> Install efficient and effective data system</td>
<td></td>
</tr>
<tr>
<td>Data Source: Documentation of selection, testing and</td>
<td></td>
</tr>
<tr>
<td>implementation of data system</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 1 Estimated Incentive Payment:</strong> $9,640.01</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process Milestone 2 [P-4]: Conduct Plan Do Study Act cyber to continually improve</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1:</strong> Document use of PDSA in planning process</td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> Utilize a systematic cyclical process for quality improvement</td>
<td></td>
</tr>
<tr>
<td>Data Source: Program documentation</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 2 Estimated Incentive Payment:</strong> $11,551.73</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process Milestone 3 [P-5]: Disseminate lessons learned and best practices</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1:</strong> Documentation of best practices and lessons learned</td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> Share lessons learned to add to knowledge base and inform others</td>
<td></td>
</tr>
<tr>
<td>implementing similar projects</td>
<td></td>
</tr>
<tr>
<td>Data Source: Program Documentation</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 3 Estimated Incentive Payment:</strong> $11,551.73</td>
<td></td>
</tr>
</tbody>
</table>

**Outcome Improvement Target 1 [IT-7.8] Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider**

<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount: $9,640.02</th>
<th>Year 3 Estimated Outcome Amount: $23,103.47</th>
<th>Year 4 Estimated Outcome Amount: $25,247.96</th>
<th>Year 5 Estimated Outcome Amount: $54,638.02</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $112,628
2.12.3: Implement/Expand Care Transitions Programs, “Other” project option to reduce the incidence of hospital readmissions within 30 days of discharge of Medicare Fee For Service and Dual Eligible individuals that are hospitalized resulting from chronic disease such as Heart Failure (HF).

**Unique Project ID:** 0937740-08.2.10  
**Performing Provider Name/TPI:** City of Houston Department of Health and Human Services/0937740-08

**Project Summary:** Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 4 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

**Intervention(s):** This expansion project, modeled after an existing Coleman Transitions Intervention, utilizes case managers, coaches and navigators to improve transitions of patients from the inpatient hospital setting to other care settings, improve quality of care, reduce avoidable readmissions for high risk heart failure beneficiaries and document measurable savings to the Medicare program.

**Need for the Project:** Many patients discharged from an inpatient return to the hospital within 30 days. Nearly one in five patients discharged from a hospital—approximately 2.6 million individuals—is readmitted within 30 days, at a cost of over $26 billion every year. Many of these hospital readmissions are considered to be avoidable and indicators of poor care or missed opportunities to better coordinate care.

**Target Population:** The primary target population is at risk patients ages 60 years or older. The majority of clients will be Medicaid or Medicare beneficiaries. This project will expand to additional geographic areas beyond the are covered by the current project. It is expected that 25% of the patients referred for the Care Transitions Program through the Methodist Hospital System will be Medicaid patients. In addition to this, a proportion of patients will be dual-eligible. Medicaid patients with CHF from the large Methodist Hospital System will be channeled to the Care Transitions program for meeting the needs of the program’s target population.

**Category 1 or 2 expected patient benefits:** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies by 5% over baseline in DY4 and by 10% over baseline in DY5. 30 patients/month will be enrolled in DY3 for baseline, and 40 patients/month in DY4 and 50 patients/month will be enrolled in DY5.
Category 3 outcomes [IT-3.2] Reduce Congestive Heart Failure 30 day readmission rate by 10% over baseline in DY4 and by 25% over baseline in DY5 among individuals that complete the program.

Title of Outcome Measure (Improvement Target): IT-3.2 Congestive Heart Failure 30 day readmission rate (Standalone measure)  
Unique RHP Outcome identification number(s): 0937740-08.3.2  
Performing Provider/TPI: City of Houston Department of Health and Human Services/0937740-08  
Outcome Measure Description: IT-3.2 Congestive Heart Failure 30 day readmission rate (Standalone measure)  
Heart failure is associated with high rehospitalization rates, often due to preventable complications resulting from patients’ inability to adequately self-manage the condition and poorly implemented transitions to the next care setting. Programs that provide adequate guidance at discharge, appropriate medication management, and appropriate followup with patients during times of transition can reduce readmission rates and improve quality of care. Congestive heart failure (CHF) is the leading cause of hospitalization among older patients; furthermore, heart failure is associated with a substantial economic burden, with costs totaling $29.6 billion in 2006. Almost one-third of heart failure patients are readmitted within 30 days of discharge. Causes of heart failure rehospitalization indicate a number of factors that could be addressed during the discharge process. These include, but are not limited to, deficiencies in patient self-care education, inappropriate medication reconciliation, poor communication among health care providers between sites of care, and lack of a plan for appropriate medical followup after discharge. Hospitalized patients are commonly subject to inadequate discharge processes that lead to clinical deterioration and increase the likelihood of rehospitalization.

Process Milestones:  
• DY 2  
  ○ P-7: Milestone: Develop and implement an outreach and marketing strategy  
• DY 3  
  ○ P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve program  
  ○ P-5: Milestone: Disseminate lessons learned and best practices

Outcome improvement targets for each year:  
• DY 4:  
  ○ IT-3.2 Reduce Congestive Heart Failure 30 day readmission rate by 10% over baseline.  
• DY 5  
  ○ IT-3.2 Reduce Congestive Heart Failure 30 day readmission rate by 25% over baseline.

Rationale: The process milestones P4 and P5 were chosen for this project based on the need for documentation of baseline and continuous quality improvements in program for reduction of dental caries. The PDSA cycle will inform systematic data driven program improvements. Inadequate access to dental services compounds other health issues.
Congestive heart failure is one of the most common conditions that is associated with rehospitalizations. Each year over 1 million people are admitted to an inpatient setting for HF, and 27% of patients with HF on Medicare are readmitted within 30 days (Jencks, Williams, & Coleman, 2009). For chronic heart failure patients, case management interventions involving telephone follow-up reduce all-cause readmissions and all-cause mortality a year after discharge. Therefore, our outcome measure relates to reducing readmissions due to congestive heart failure.

Some of the reasons identified for re-admissions are nonadherence (medications, diet, self-monitoring, and communication with provider) is a significant problem in patients with heart failure and frequently contributes to morbidity and increased resource utilization.

**Outcome Measure Valuation:**
The Outcome measure was valued at 84.18% of the overall assigned project value for the associated Category 2 project in year 3, 84.18% in Year 4 and 84.18% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HHDHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HHDHS Valuation Tool). HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs, 4) Cost Avoidance, 5) Partnership Collaboration and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a predetermined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HHDHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease, 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HHDHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a predetermined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDDHS gave the Prioritization score a weight of 50% and the Public Health Impact score a weight of 50% to determine the overall project value for the plan. Community Care Transitions received a composite Prioritization score of 10 and a Public Health Impact score of 10.

**Reference**
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong> [P-7]</td>
<td><strong>Process Milestone 2</strong> [P-4]: Conduct Plan Do Study Act cycle to continually improve</td>
<td><strong>Outcome Improvement Target 1</strong> [IT-3.2]</td>
<td><strong>Outcome Improvement Target 2</strong> [IT-3.2]</td>
</tr>
<tr>
<td>Develop and implement an outreach and marketing strategy to engage partners and stakeholders</td>
<td>Metric 1: Document use of PDSA in planning process</td>
<td>Congestive Heart Failure 30 day readmission rate (Standalone measure)</td>
<td>Congestive Heart Failure 30 day readmission rate (Standalone measure)</td>
</tr>
<tr>
<td>Goal: Promotion of program and engagement of stakeholders</td>
<td>Goal: Utilize a systematic cyclical process for quality improvement</td>
<td>Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission, who enrolled and completed the program.</td>
<td>Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission, who enrolled and completed the program.</td>
</tr>
<tr>
<td>Data Source: Program documentation</td>
<td>Data Source: Program documentation</td>
<td>Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission, enrolled in the program.</td>
<td>Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission, enrolled in the program.</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment: $61,445.41</td>
<td><strong>Process Milestone 3</strong> [P-5]: Disseminate lessons learned and best practices</td>
<td>Goal: Reduce readmission rate by 10% over baseline</td>
<td>Goal: Reduce readmission rate by 25% over baseline</td>
</tr>
<tr>
<td>Metric 1: Documentation of best practices and lessons learned</td>
<td>Goal: Share lessons learned to add to knowledge base and inform others implementing similar projects</td>
<td>Data Source: Patient data and Program records</td>
<td>Data Source: Patient data and Program records</td>
</tr>
<tr>
<td>Goal: Share lessons learned to add to knowledge base and inform others implementing similar projects</td>
<td>Data Source: Program Documentation</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $134,292.34</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $290,627.78</td>
</tr>
<tr>
<td>Milestone 3 Estimated Incentive Payment: $61,445.41</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2 Estimated Outcome Amount:** $51,276.68  
**Year 3 Estimated Outcome Amount:** $122,890.82  
**Year 4 Estimated Outcome Amount:** $134,292.34  
**Year 5 Estimated Outcome Amount:** $290,627.78

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $599,088
Columbus Community Hospital

Pass 1
**Title of Outcome Measure (Improvement Target):** IT-3.1 All cause 30 day readmission rate – NQF 1789\(^{250}\) (Standalone measure)

**Unique RHP Outcome Identification Number:** Columbus Community Hospital (CCH)/135033204.3.1

**Outcome Measure Description**
OD-3 Potentially Preventable Re-Admissions – 30 day Re-admission rates IT-3.1 All cause 30 day readmission rate – NQF 1789\(^{250}\) (Standalone measure)

**Process Milestones:**
DY2 – P-1
- DY3 – P-3

**Outcome Improvement Targets:**
- DY4 – IT-3.1
- DY5 – IT-3.1

**Rationale:**
Telehealth is being implemented at Columbus Community Hospital for the purpose of expanding weekend pharmacist oversight to include Saturdays, Sundays and Holidays. Presently there is no pharmacist coverage on those days. The presence of an oversight pharmacist via telehealth capabilities will lead to a reduction in medication errors. This is a direct relationship to readmission rates which has been increasing and on the last Pepper report (March 2012) had risen to 21.4%.

Improvement measure 3.1 will help us tract the readmission rate for all-cause admissions. The population will only include patients 65 are older.

**Outcome Measure Valuation**
The addition of the telehealth service is the primary cost in year two and three. This will require implementation and training of the staff to use the service effectively. In subsequent years the hospital will experience a reduction in the rate of unplanned readmissions thereby initiating cost savings to respective payers such as CMS. The total anticipated values are estimated to be (total of years 2, 3, 4, 5)
<table>
<thead>
<tr>
<th>Related Category 1:</th>
<th>135033204.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/ Baseline:</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Project planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 2</strong> [P-3]: Develop and test data systems to ensure capture of all inpatient discharges for program of specialist consultation</td>
</tr>
<tr>
<td>Goal: Reduction in the readmission rate of 1%</td>
<td>Goal: Reduction in readmission rate of 1% from year 2</td>
</tr>
<tr>
<td>Data Source: EHR, project data</td>
<td>Data Source: EHR, project data</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $30,640.00</td>
<td>Process Milestone 3 Estimated Incentive Payment : $36,600.00</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $30,640.00</td>
<td>Year 3 Estimated Outcome Amount: $36,600.00</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $177,740.00
El Campo Memorial Hospital
Pass 1
Title of Outcome Measure (Improvement Target): IT-6.1(1) Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification number(s): 131045004.3.1

Outcome Measure Description:
Since this is a new project for El Campo Memorial Hospital, we will use DY 2 & DY 3 to plan the project and establish baseline rates. In DY 4 & DY 5, we will measure IT-6.1 Percent improvement over baseline of patient satisfaction scores specifically related to the measure IT-6.1.1 Patients are getting timely care, appointments, and information. Currently, a patient satisfaction survey does not exist to capture this measure at El Campo Memorial Hospital. Therefore, the baseline will be set at 0. However, we expect to improve this measure by 5% by the end of the waiver.

Rationale:
El Campo Memorial Hospital has selected the process milestones and outcome improvement targets because we are certain if the patient receives timely healthcare and education, they are more likely to continue leading healthy lives and obtaining preventing healthcare on a regular basis which ultimately leads to reduced healthcare costs.

Outcome Measure Valuation:
We considered both the costs and benefits to our organization and community in order to value the Outcome Measure – IT-6.1 Percent improvement over baseline of patient satisfaction scores. We believe it will take DY2 and DY3 to effectively develop and plan the Outcome Improvement Targets in DY4 and DY5. We do not currently perform or contract with a company to perform surveys for outpatient services, but we intend to select a vendor in DY 2. We believe with the improvement in patient satisfaction scores specifically the improvement target of patients getting timely care, appointments and information, this will decrease unnecessary Emergency Room visits, hospital stays, etc. because patients will be receiving the care and attention they need on a consistent and dependable basis. This Outcome Measure will serve the total outpatient service population of El Campo Memorial Hospital, and it will ultimately assist El Campo and the surrounding communities to live healthier lives and be healthier communities.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>131045004.2.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be established in DY3.</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
</tr>
</tbody>
</table>
| **Process Milestone 1 [P-1]**: Project Planning – identify current capacity and needed resources, determine timelines and document implementation plans | **Process Milestone 2 [P-4]**: Establish baseline rates  
Data Source: Meeting minutes, agenda and plan | **Outcome Improvement Target 1 [IT-6.1]**: Percent improvement over baseline of patient satisfaction scores – TBD.  
Improvement Target: Increase patient satisfaction scores for measure 1) Patient is getting timely care, appointments, and information.  
Data Source: Patient Survey | **Outcome Improvement Target 2 [IT-6.1]**: Percent improvement over baseline of patient satisfaction scores – TBD.  
Improvement Target: Additional increase of patient satisfaction scores for measure 1) Patient is getting timely care, appointments, and information.  
Data Source: Patient Survey |
| Process Milestone 1 Estimated Incentive Payment: $21,110 | Process Milestone 2 Estimated Incentive Payment: $24,469 | Outcome Improvement Target 1 Estimated Incentive Payment: $39,264 | Outcome Improvement Target 2 Estimated Incentive Payment: $93,892 |

**Year 2 Estimated Outcome Amount:** (add incentive payments amounts from each milestone/outcome improvement target): $21,110  
**Year 3 Estimated Outcome Amount:** $24,469  
**Year 4 Estimated Outcome Amount:** $39,264  
**Year 5 Estimated Outcome Amount:** $93,892

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $178,734
Fort Bend County Clinical Health Services
Pass 1
Category 3 – Outcome Measure

**Improvement Target:** IT-9.2 ED appropriate utilization

**Unique RHP Outcome Identification Number:** 2967606-01 3.1

**Performing Provider:** Fort Bend County Clinical Health Services / 2967606-01

**Outcome Measure Description:**
OD- 9 – Right Care, Right setting will be defined as the number of persons with behavioral health crisis who had a preventable visit to emergency rooms (ER)

**Process Milestones:**
DY2: P-1  
DY3: P-2, P-3  
DY4: P-4, P-5  
DY5: P-4, P-5

**Outcome Improvement Target(s) for each year:**
DY 4: IT 9.2 Emergency Room visits for target conditions
- Reduce % (TBD) of ER visits for behavioral health/ substance abuse
DY 5: IT 9.2 Emergency Room visits for target conditions
- Reduce % (TBD) of ER visits for behavioral health/ substance abuse

**Rationale:**
Process milestone P-1 was chosen to ensure engagement of multiple stakeholders, delineation of project timeliness and activities. Process milestones P-2 and P-3 are especially critical to the project and include definition of data to be collected, data sources, data tracking mechanisms, and establishment of baselines. The success of the FBC project will be determined by the ability to track outcomes for persons with behavioral health needs who are in “crisis” and access crisis services. Data systems need to be integrated to facilitate communication about the patients’ needs, linking to appropriate services and measuring outcomes. The project will work with various partners in the region as well as the county’s IT department to develop the most efficient data tracking system. The data will be used as part of the project's quality improvement cycle.

Process milestones P-4 and P-5 ensure continuous quality improvement, data driven decision making, identification of “lessons learned” and dissemination to stakeholders. These will allow the use of real time data for continuous quality improvement, engagement of multiple stakeholders, and identification of best practices. The need for information sharing and continuous evaluation cannot be overstated. Within the project, staff will implement the Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Achieving high quality outcomes depends on continuous assessment of what has been done and flexibility to apply lessons learned to the next phase of a process. The PDSA improvement process will provide for a continuous quality improvement process, which will guide decision making and timelines developed to reach milestones while delivering quality products.

Findings will need to be disseminated, including lessons learned and best practices, so that stakeholders can, in turn, provide additional input and/or validation. To achieve this
feedback loop, the project will conduct meetings of stakeholders, project staff, RHP partners, and other key parties to gather relevant information. These stakeholder meetings will be quarterly.

Stakeholder input is not only critical to the design and implementation of this project but also to its sustainability. Dissemination of our activities to the community and the various stakeholders will be critical. Persons with behavioral health disorders or their families often access 911 crisis services as their first choice for help, and first responders have become the default interveners for behavioral health crisis in FBC. First responders have limited options for these patients and complex situations often arise that require a diligent assessment and delineation of safety and clinical need. The goal is to direct the person to the right level of care and to ensure patient and community safety. There will be many challenges as we implement this project including community education and awareness of a new “response” system.

The Improvement Target will be further defined in DY4 and DY5 based on the data collected in DY2 and DY3. The outcome measure chosen, reduction of ER utilization for behavioral health/substance abuse crises is of great significance and directly related to the Category 1 project. In 2011, FBC Emergency Management Services (EMS) responded to 1, 171 mental health crisis calls, representing almost a 100% percent increase in the past 6 years. Of these 847 patients were transported to a hospital. Analysis of the EMS response calls indicated that the majority of the behavioral health calls are not medical emergencies and unnecessary. The FBC project will create a “Behavioral Health Crisis Response and Intervention” system that will reduce EMS transports and ED visits and admissions.

**Outcome Measure Valuation:**
Outcome valuation follows the same process as for the program metrics. Cost avoidance of State Hospital visits, incarceration, EMS transport, ER visits and in-patient stays for the county indigent program if the established targets are met. The total cost avoidance value anticipated is in excess of $16 million. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $10,016,863.

**Plan for Learning Collaborative:** We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region, 3 Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region’s healthcare system.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Process Milestone 1 [P-1]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans | **Process Milestone 2 [P-2]:** Establish baseline rates  
*Metric 1:* Number of crisis intervention team contacts  
*Data Source:* CIT reports; monthly management reports  
*Goal:* Establish baseline number | **Process Milestone 4**  
[P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
*Metric 1:* Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles  
*Data Source:* Project reports including examples of how real-time data has been used to guide continuous quality improvement  
*Goal:* To improve processes and outcomes by implementing data-driven course corrections and innovations | **Process Milestone 4**  
[P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
*Metric 1:* Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles  
*Data Source:* Project reports including examples of how real-time data has been used to guide continuous quality improvement  
*Goal:* To improve processes and outcomes by implementing data-driven course corrections and innovations |
| **Process Milestone 2 Estimated** | **Process Milestone 2 Estimated** | **Process Milestone 4 Estimated**  
Incentive Payment: $118,132 | **Process Milestone 4 Estimated**  
Incentive Payment: $189,753.333 |
| **Process Milestone 3 [P-3]:** Develop and test data systems  
*Metric 1:* Review data tracking systems for target population  
*Data Source:* Project records, summary of reviews  
*Goal:* Develop data tracking systems that allow for identification of behavioral health needs and outcomes | **Process Milestone 3 Estimated**  
Incentive Payment: $118,132 | **Process Milestone 4 Estimated**  
Incentive Payment: $87,440.667 | **Process Milestone 5**  
[P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders  
*Metric 1:* Report status, progress and lessons learned to stakeholders (4 times per year)  
*Data Source:* Minutes of |
| **Process Milestone 3 Estimated**  
Incentive Payment: $118,132 | **Process Milestone 3 Estimated**  
Incentive Payment: $118,132 | **Process Milestone 4 Estimated**  
Incentive Payment: $87,440.667 | **Process Milestone 5**  
[P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders  
*Metric 1:* Report status, progress and lessons learned to stakeholders (4 times per year)  
*Data Source:* Minutes of |
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Related Category 1 or 2 Projects:</strong></td>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>Outcome Improvement Target</strong></td>
<td><strong>Outcome Improvement Target</strong></td>
</tr>
<tr>
<td><strong>Fort Bend County Clinical Health Services</strong></td>
<td><strong>TBD</strong></td>
<td><strong>Baseline/Goal: TBD / Reduce emergency visits for behavioral health/ substance abuse by 10%</strong></td>
<td><strong>Baseline/Goal: DY4 baseline / Reduce emergency visits for behavioral health/ substance abuse by 10% versus DY4 baseline</strong></td>
</tr>
<tr>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td><strong>Process Milestone 5 Estimated Incentive Payment:</strong> $87,440.666</td>
<td><strong>Data Source:</strong> EMS and ED encounter data, patient data, referral sources</td>
<td><strong>Data Source:</strong> Minutes of meetings, report to Commissioner’s Court</td>
</tr>
<tr>
<td><strong>Outcome Improvement Target</strong></td>
<td><strong>Outcome Improvement Target</strong></td>
<td><strong>Data Source:</strong> Minutes of meetings, report to Commissioner’s Court</td>
<td><strong>Data Source:</strong> Minutes of meetings, report to Commissioner’s Court</td>
</tr>
<tr>
<td><strong>[IT- 9.2] ED appropriate utilization</strong></td>
<td><strong>Baseline/Goal: TBD / Reduce emergency visits for behavioral health/ substance abuse by 10%</strong></td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
</tr>
<tr>
<td><strong>Improvement Target:</strong> TBD</td>
<td><strong>Data Source:</strong> EMS and ED encounter data, patient data, referral sources</td>
<td><strong>Process Milestone 5 Estimated Incentive Payment:</strong> $189,753.333</td>
<td><strong>Process Milestone 5 Estimated Incentive Payment:</strong> $189,753.333</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $87,440.666</td>
<td><strong>Estimated Incentive Payment:</strong> $189,753.334</td>
<td><strong>Process Milestone 5 Estimated Incentive Payment:</strong> $189,753.333</td>
<td><strong>Estimated Incentive Payment:</strong> $189,753.334</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Outcome Amount:** $109,188  
**Year 3 Estimated Outcome Amount:** $236,264  
**Year 4 Estimated Outcome Amount:** $262,322  
**Year 5 Estimated Outcome Amount:** $569,260
| Related Category 1 or 2 Projects: | 2967606-01 1.1 |
| Starting Point/Baseline: | TBD |

| Year 2  | Year 3  | Year 4  | Year 5  |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYS 2-5)*: $1,177,034
Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes Care
Unique RHP Outcome Identification Number: 2967606-01 3.2
Performing Provider Name / TPI: Fort Bend County Clinical Health Services /2967606-01

Outcome Measure Description:
DY2 and DY3 will focus on the Process Milestones necessary to establish and test the system prior to measuring health outcomes for the patients and cost avoidance for the program.

DY2 Process Milestones:
• P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
• P-3 Develop and test data systems

DY3 Process Milestones:
• P-2 Establish baseline rates of HbA1c in the targeted population with diabetes.
• P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

DY4 and DY5 Outcome Improvement Target
IT-1.10: Reduce the percentage of referred diabetic patients with HbA1c poor control (>9%)

Rationale:
The process milestones were selected to help expand a new program of Care Coordination (patient navigation) within the local FQHC. The project with involve coordination of several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county, particularly those who inappropriately or repeatedly use high cost medical resources for chronic conditions that could better be managed in a medical home on an outpatient basis with effective care coordination and other resource provision. The planning stage and development of a data system will be the focus of DY2. During DY3, the project will be implemented and as patients are identified and referred in to the program, baseline data, which is not currently available on the population will be gathered. At the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved.

The focus of DY4 and DY5 will be to continue the program as designed or modified and measure the outcome change for the target population. Target change for the outcomes were developed from similar program outcomes in other locations. As a measure of the success of the program in handling chronic disease conditions in the population, one measure of positive outcome was selected, that of reduction in poor control of blood glucose levels in diabetics measured by the HbA1c level.

Outcome Measure Valuation:
Outcome valuation follows the same process as for the program metrics. Cost avoidance of EMS transport, ED visits and in-patient stays for the county indigent program if the established targets are met, to be replaced by the lower cost Care Coordination at the FQHC. The total cost avoidance value anticipated for the related category 2 project 2967606-01 2.1 is $2,997,280. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $2,942,005. $2,611,029 of the total maximum payment is distributed to the category 2 project 2967606-01 2.1. The remaining
$330,976 of the maximum payment is distributed evenly among the 3 outcome measure improvement targets (IT-1.10, IT-9.2, and IT-9.4).
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Process Milestone 2 [P-2]: Establish baseline rates – of baseline HbA1c in the targeted population with diabetes. Data Source: EHR, ePCR</th>
<th>Process Milestone 3 [P-3]: Develop and test data systems Data Source: Documentation of systems and results of tests</th>
<th>Process Milestone 4 [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: PDSA data and actions</th>
<th>Process Milestone 5 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Documentation of activities and plans</td>
<td>Process Milestone 3 Estimated Incentive Payment: $7,713</td>
<td>Process Milestone 3 Estimated Incentive Payment: $7,713</td>
<td>Outcome Improvement Target 1 [IT-1.10]: Diabetes care: HbA1c poor control (&gt;9.0%) Baseline / Goal: DY3 baseline Improvement Target: 10% reduction from baseline Data Source: ePCR, HER</td>
<td>Outcome Improvement Target 2 [IT-1.10]: Diabetes care: HbA1c poor control (&gt;9%) Baseline / Goal: DY3 baseline Improvement Target: 20% reduction from baseline Data Source: ePCR, HER</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Improvement Target 1 [IT-1.10]: Diabetes care: HbA1c poor control (&gt;9.0%) Baseline / Goal: DY3 baseline Improvement Target: 10% reduction from baseline Data Source: ePCR, HER</th>
<th>Outcome Improvement Target 2 [IT-1.10]: Diabetes care: HbA1c poor control (&gt;9%) Baseline / Goal: DY3 baseline Improvement Target: 20% reduction from baseline Data Source: ePCR, HER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: $10,694</td>
<td>Year 3 Estimated Outcome Amount: $23,140</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $115,282*
Title of Outcome Measure (Improvement Target): OD-9 Right Care, Right Setting - IT 9.2 – ED Appropriate Utilization / Reduce ED use in target population referred to Care Coordination Program

Unique RHP Outcome Identification Number: 2967606-01 3.3

Performing Provider Name / TPI: Fort Bend County Clinical Health Services / 2967606-01

Outcome Measure Description:

DY2 and DY3 will focus on the Process Milestones necessary to establish and test the system prior to measuring health outcomes for the patients and cost avoidance for the program.

DY2 Process Milestones:

- P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P-3 Develop and test data systems

DY3 Process Milestones:

- P-2 Establish baseline rates – of ED use by target population encountered and referred.
- P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

DY4 and DY5 Outcome Improvement Target

- IT-9.2: ED Appropriate Utilization / Reduce ED use in target population referred to Care Coordination Program

Rationale:

The process milestones were selected to help expand a new program of Care Coordination (patient navigation) within the local FQHC. The project with involve coordination of several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county, particularly those who inappropriately or repeatedly use high cost medical resources for non-urgent or chronic conditions that could better be managed in a medical home on an outpatient basis with effective care coordination and other resource provision. The planning stage and development of a data system will be the focus of DY2. During DY3, the project will be implemented and as patients are identified and referred in to the program, baseline data, which is not currently available on the population will be gathered. At the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved.

The focus of DY4 and DY5 will be to continue the program as designed or modified and measure the outcome changes for the target population in terms of use of the ED. Target changes for this outcome were developed from similar program outcomes in other locations.

Outcome Measure Valuation:

Outcome valuation follows the same process as for the program metrics. Cost avoidance of EMS transport, ED visits and in-patient stays for the county indigent program if the established targets are met, to be replaced by the lower cost Care Coordination at the FQHC. The total cost avoidance value anticipated for the related category 2 project 2967606-01 2.1 is $2,997,280. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $2,942,005. $2,611,029 of the total maximum payment is distributed to the category 2 project 2967606-01 2.1. The remaining $330,976 of the maximum payment is distributed evenly among the 3 outcome measure improvement targets (IT-1.10, IT-9.2, and IT-9.4).
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>2967606-01 2.1</th>
<th>2967606-01</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fort Bend County</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1 [P-1]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
Data Source: Documentation of activities and plans  
Process Milestone 1 Estimated Incentive Payment (*maximum amount*): $5,347

**Process Milestone 2 [P-3]:** Develop and test data systems  
Data Source: Documentation of systems and results of tests  
Process Milestone 2 Estimated Incentive Payment: $5,347

**Process Milestone 3 [P-2]:** Establish baseline rates – of ED use by target population encountered and referred.  
Data Source: EHR, ePCR  
Process Milestone 3 Estimated Incentive Payment: $7,714

**Process Milestone 4 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.  
Data Source: PDSA data and actions  
Process Milestone 3 Estimated Incentive Payment: $7,713

**Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders  
Data Source: Reports provided  
Process Milestone 3 Estimated Incentive Payment: $7,713

**Outcome Improvement Target 1 [IT-9.2]:** ED Appropriate Utilization  
Baseline/Goal: DY 3 ED use for target population referred to Care Coordination Program  
Data Source: ePCR, EHR  
Outcome Improvement Target 1 Estimated Incentive Payment: $25,693

**Outcome Improvement Target 1 [IT-9.2]:** ED Appropriate Utilization  
Baseline/Goal: DY 3 ED use for target population referred to Care Coordination Program  
Data Source: ePCR, EHR  
Outcome Improvement Target 1 Estimated Incentive Payment: $55,755

**Year 2 Estimated Outcome Amount:** $10,694

**Year 3 Estimated Outcome Amount:** $23,140

**Year 4 Estimated Outcome Amount:** $25,693

**Year 5 Estimated Outcome Amount:** $55,755

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**: ($add outcome amounts over DYs 2-5): $115,282
Title of Outcome Measure (Improvement Target): OD-9 Right Care, Right Setting - IT 9.4 – Other Outcome Improvement Target / Reduce EMS transport use in target population referred to Care Coordination Program

Unique RHP Outcome Identification Number: 2967606-01 3.4
Performing Provider Name / TPI: Fort Bend County Clinical Health Services /2967606-01

Outcome Measure Description:
DY2 and DY3 will focus on the Process Milestones necessary to establish and test the system prior to measuring health outcomes for the patients and cost avoidance for the program.

DY2 Process Milestones:
- P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P-3 Develop and test data systems

DY3 Process Milestones:
- P-2 Establish baseline rates – of EMS transport use by target population encountered and referred
- P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

DY4 and DY5 Outcome Improvement Target:
- IT-9.4: Other Outcome Improvement Target (Reduce EMS transport use in target population referred to Care Coordination Program)
  a) Baseline measurement of rate of inappropriate transports in the target population
     a. Measured by review of EMS transport data during DY2 to determine payor source of non-emergent transports by Fort Bend County EMS
  b) Measurement of rate of inappropriate EMS transports in the referred population during DY3, DY4 and DY5
     a. Measured by review of EMS transport data during DY3, 4 and 5 to determine non-emergent transports by Fort Bend County EMS

Rationale:
The process milestones were selected to help expand a new program of Care Coordination (patient navigation) within the local FQHC. The project with involve coordination of several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county, particularly those who inappropriately or repeatedly use high cost medical resources for non-urgent or chronic conditions that could better be managed in a medical home on an outpatient basis with effective care coordination and other resource provision. The planning stage and development of a data system will be the focus of DY2. During DY3, the project will be implemented and as patients are identified and referred in to the program, baseline data, which is not currently available on the population will be gathered. At the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved.
The focus of DY4 and DY5 will be to continue the program as designed or modified and measure the outcome change for the target population in terms of use of EMS transport. Target change for this outcome was developed from similar program outcomes in other locations.

**Outcome Measure Valuation:**
Outcome valuation follows the same process as for the program metrics. Cost avoidance of EMS transport, ED visits and in-patient stays for the county indigent program if the established targets are met, to be replaced by the lower cost Care Coordination at the FQHC. The total cost avoidance value anticipated for the related category 2 project 2967606-01 2.1 is $2,997,280. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $2,942,005. $2,611,029 of the total maximum payment is distributed to the category 2 project 2967606-01 2.1. The remaining $330,976 of the maximum payment is distributed evenly among the 3 outcome measure improvement targets (IT-1.10, IT-9.4, and IT-9.5).

**Plan for Learning Collaborative:** We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region, 3 Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region’s healthcare system.
### Related Category 1 or 2 Projects:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Develop and test data systems</td>
<td>Establish baseline rates – of EMS use by target population encountered and referred. Data Source: EHR, ePCR</td>
<td>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: PDSA data and actions</td>
<td>Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports provided</td>
</tr>
<tr>
<td>Data Source: Documentation of activities and plans</td>
<td>Data Source: Documentation of systems and results of tests</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Starting Point/Baseline:

**Data not available**

### Year 2 (10/1/2012 – 9/30/2013)

**Process Milestone 1 [P-1]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

Data Source: Documentation of activities and plans

Process Milestone 1 Estimated Incentive Payment (maximum amount): $5,347

**Process Milestone 2 [P-3]:** Develop and test data systems.

Data Source: Documentation of systems and results of tests

Process Milestone 2 Estimated Incentive Payment: $5,347

### Year 3 (10/1/2013 – 9/30/2014)

**Process Milestone 3 [P-2]:** Establish baseline rates – of EMS use by target population encountered and referred.

Data Source: EHR, ePCR

Process Milestone 3 Estimated Incentive Payment: $7,714

**Process Milestone 4 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

Data Source: PDSA data and actions

Process Milestone 3 Estimated Incentive Payment: $7,713

**Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders.

Data Source: Reports provided

Process Milestone 3 Estimated Incentive Payment: $7,713

### Year 4 (10/1/2014 – 9/30/2015)

**Outcome Improvement Target 1 [IT-9.4]:** Other outcome improvement target / Reduce EMS transport use in target population referred to Care Coordination Program.

Baseline/Goal: DY3 EMS transport use for the target population / Improvement Target: 15% reduction from baseline.

Data Source: ePCR, HER

Outcome Improvement Target 1 Estimated Incentive Payment: $25,693

**Outcome Improvement Target 2 [IT-9.4]:** Other outcome improvement target / Reduce EMS transport use in target population referred to Care Coordination Program.

Baseline/Goal: DY3 EMS transport use for the target population / Improvement Target: 20% reduction from baseline.

Data Source: ePCR, HER

Outcome Improvement Target 2 Estimated Incentive Payment: $55,755

### Year 5 (10/1/2015 – 9/30/2016)

**Outcome Improvement Target 1 [IT-9.4]:** Other outcome improvement target / Reduce EMS transport use in target population referred to Care Coordination Program.

Baseline/Goal: DY3 EMS transport use for the target population / Improvement Target: 15% reduction from baseline.

Data Source: ePCR, HER

Outcome Improvement Target 1 Estimated Incentive Payment: $25,693

**Outcome Improvement Target 2 [IT-9.4]:** Other outcome improvement target / Reduce EMS transport use in target population referred to Care Coordination Program.

Baseline/Goal: DY3 EMS transport use for the target population / Improvement Target: 20% reduction from baseline.

Data Source: ePCR, HER

Outcome Improvement Target 2 Estimated Incentive Payment: $55,755

### Year 2 Estimated Outcome Amount: $10,694

### Year 3 Estimated Outcome Amount: $23,140

### Year 4 Estimated Outcome Amount: $25,693

### Year 5 Estimated Outcome Amount: $55,755

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $115,282
Fort Bend County Clinical Health Services

Pass 2
Category 3 Narrative

Identification of the Category 3 Outcome:

**Title of Outcome Measure** (Improvement Target): OD-9- Right Care, Right Setting

**Unique RHP Outcome Identification Number:** 2967606-01 3.5
**Performing Provider:** Fort Bend County Clinical Health Services / 2967606-01

**Outcome Measure Description:**
IT9.1 – Decrease in mental health admissions and readmissions to criminal justice settings (juvenile detention)

**Process Milestones:**
DY2: P-1
DY3: P-2, P-3
DY4: P-4, P-5
DY5: P-4, P-5

**Outcome Improvement Target(s) for each year:**
DY 4: IT 9.1 Admissions to juvenile detention for youth with complex behavioral health needs
- Reduce % (TBD) admissions to juvenile detention for youth with complex behavioral health needs

DY 5: IT 9.1 Admissions to juvenile detention for youth with complex behavioral health needs
- Reduce % (TBD) of admissions to juvenile detention for youth with complex behavioral health needs

**Rationale:** Process milestone P-1 was chosen to ensure engagement of multiple stakeholders, delineation of project timelines and activities. Process milestones P-2 and P-3 are especially critical to the project and include definition of data to be collected, data sources, data tracking mechanisms, and establishment of baselines. The success of the FBC project will be determined by the ability to track outcomes for persons with youth with behavioral health needs who come into contact with law enforcement and are diverted into appropriate community based clinical services. The project will work with various partners in the region as well as the county’s IT department to develop the most efficient data tracking system. The data will be used as part of the project’s quality improvement cycle.

Process milestones P-4 and P-5 ensure continuous quality improvement, data driven decision making, identification of “lessons learned” and dissemination to stakeholders. These will allow the use of real time data for continuous quality improvement, engagement of multiple stakeholders, and identification of best practices. The need for information sharing and continuous evaluation cannot be overstated. Within the project, staff will implement the Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Achieving high quality outcomes depends on continuous assessment of what has been done and flexibility to apply lessons learned to the next phase of a process. The PDSA improvement process will
provide for a continuous quality improvement process, which will guide decision making and timelines developed to reach milestones while delivering quality products.

Findings will need to be disseminated, including lessons learned and best practices, so that stakeholders can, in turn, provide additional input and/or validation. To achieve this feedback loop, the project will conduct meetings of stakeholders, project staff, RHP partners, and other key parties to gather relevant information. These stakeholder meetings will be quarterly. Stakeholder input is not only critical to the design and implementation of this project but also to its sustainability. Dissemination of our activities to the community and the various stakeholders will be critical.

The Improvement Target will be defined in DY4 and DY5 based on the data collected in DY2 and DY3. The baseline percentage will be determined in DY3. The outcome measure chosen, reduction in mental health admissions and readmissions to criminal justice settings (juvenile detention) is of great significance and directly related to the Category 2 (Fort Bend County Behavioral Health Juvenile Diversion) project. In 2011, approximately 40 to 45% of the youth “booked” into the Fort Bend County Juvenile Detention had a mental health disorder. This represents an estimated 100% increase in the last 6 years. The length of stay for youth with mental illness (average of 41 days for 2011) is 51% higher than youth without out a mental health disorder (average of 27 days). The average daily cost for treating a youth in detention facility is also significantly higher (approximately $350 per day). Juvenile probation departments and detention facilities have become the default mental health treatments centers for many youth with behavioral health disorders especially those with no insurance or Medicaid. The scarcity of appropriate clinical services for these youth and their families is a significant gap in Fort Bend County. As a result, juvenile probation, much like the adult criminal justice systems, has become the default intervention system. Yet, we know that many of these youth would achieve better outcomes if treated in community based programs with appropriate level of services. The cost effectiveness of community based programs versus incarceration has been well documented throughout the literature. The FBC BHJD project will implement and evaluate evidence based interventions for youth with complex behavioral health needs at risk of involvement in juvenile probation with the goal of improving outcomes for these youth and reducing admission to juvenile detention.

**Outcome Measure Valuation:**
Outcome valuation follows the same process as for the program metrics. Cost avoidance of days in Juvenile Detention if the established targets are met. The total cost avoidance value anticipated is in excess of $750,000. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $750,000.
<table>
<thead>
<tr>
<th>2967606-01 3.5</th>
<th>IT 9.1</th>
<th>Decrease in mental health admissions and readmission to criminal justice settings – Juvenile Behavioral Health</th>
</tr>
</thead>
</table>

*Fort Bend County Clinical Health Services*

**2967606-01 2.2**

**Starting Point/Baseline:** TBD

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans <strong>Metric:</strong> Conduct quarterly meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information <strong>Data Source:</strong> Meetings minutes, project flow charts and timelines, meeting feedback forms <strong>Goal:</strong> To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way <strong>Process Milestone 1 Estimated Incentive Payment:</strong> $7,724</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates <strong>Metric:</strong> Number of youth referred and served by BHJD project <strong>Data Source:</strong> juvenile probation reports, booking data, law enforcement, monthly project reports <strong>Goal:</strong> Establish baseline number served in year 3 <strong>Process Milestone 2 Estimated Incentive Payment:</strong> $9,150</td>
<td>Outcome Improvement Target [IT-9.1] decrease in incarceration <strong>Baseline/Goal:</strong> TBD / Reduce incarceration for youth with behavioral health disorders % (TBD) <strong>Metric:</strong> TBD <strong>Data Source:</strong> Juvenile probation reports, booking data, law enforcement encounter data, clinical records <strong>Outcome Improvement Target Estimated Incentive Payment:</strong> $6,602</td>
<td>Outcome Improvement Target [IT-9.1] decrease in incarceration <strong>Baseline/Goal:</strong> TBD / Reduce incarceration for youth with behavioral health disorders % (TBD) <strong>Metric:</strong> TBD <strong>Data Source:</strong> Juvenile probation reports, booking data, law enforcement encounter data, clinical records <strong>Outcome Improvement Target Estimated Incentive Payment:</strong> $14,300</td>
</tr>
<tr>
<td>2967606-01 3.5</td>
<td>IT 9.1</td>
<td>Decrease in mental health admissions and readmission to criminal justice settings – Juvenile Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Fort Bend County Clinical Health Services</td>
<td>2967606-01</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:**
- 2967606-01 2.2

**Starting Point/Baseline:**
- **Year 2:** (10/1/2012 – 9/30/2013)
- **Year 3:** (10/1/2013 – 9/30/2014)
- **Year 4:** (10/1/2014 – 9/30/2015)
- **Year 5:** (10/1/2015 – 9/30/2016)

### Process Milestone 3 [P-3]:
**Develop and test data systems**
- **Metric:** Review data tracking systems for target population
- **Data Source:** Project records, summary of reviews
- **Goal:** Develop data tracking systems that allow for identification of behavioral health needs and outcomes

**Process Milestone 3 Estimated Incentive Payment:** $9,150

### Process Milestone 4:
**[P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities**
- **Metric:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
- **Data Source:** Project reports including examples of how real-time data has been used to guide continuous quality improvement

**Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations

**Process Milestone 4 Estimated Incentive Payment:** $6,601

### Process Milestone 4:
**[P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities**
- **Metric:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
- **Data Source:** Project reports including examples of how real-time data has been used to guide continuous quality improvement

**Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations

**Process Milestone 4 Estimated Incentive Payment:** $14,299
<table>
<thead>
<tr>
<th>2967606-01 3.5</th>
<th>IT 9.1</th>
<th>Decrease in mental health admissions and readmission to criminal justice settings – Juvenile Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fort Bend County Clinical Health Services</strong></td>
<td>2967606-01</td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 1 or 2 Projects:</strong></td>
<td>2967606-01 2.2</td>
<td></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>TBD</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
</tr>
<tr>
<td><strong>Process Milestone 5</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[P- 5] Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric:</strong></td>
<td>Report status, progress and lessons learned to stakeholders (4 times per year)</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td>Minutes of meetings, report to Commissioner’s Court</td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong></td>
<td>To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 5 Estimated Incentive Payment $ 6,601</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 5</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[P- 5] Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric:</strong></td>
<td>Report status, progress and lessons learned to stakeholders (4 times per year)</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td>Minutes of meetings, report to Commissioner’s Court</td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong></td>
<td>To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 5 Estimated Incentive Payment $ 14,299</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2967606-01 3.5</td>
<td>IT 9.1</td>
<td>Decrease in mental health admissions and readmission to criminal justice settings – Juvenile Behavioral Health</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Fort Bend County Clinical Health Services</strong></td>
<td>2967606-01</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>2967606-01 2.2</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 (10/1/2012 – 9/30/2013)</strong></td>
<td><strong>Year 3 (10/1/2013 – 9/30/2014)</strong></td>
<td><strong>Year 4 (10/1/2014 – 9/30/2015)</strong></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $7,724</td>
<td>Year 3 Estimated Milestone Bundle Amount: $18,300</td>
<td>Year 4 Estimated Milestone Bundle Amount: $19,804</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> <em>(add milestone bundle amounts over DYs 2-5): $88,726</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Title of Outcome Measure (Improvement Target):** IT 9.2 – ED Appropriate Utilization / Reduce ED use in target population managed by the Community Paramedic Program

**Unique RHP Outcome Identification Number:** 2967606-01 3.6 / Pass 2

**Performing Provider:** Fort Bend County Clinical Health Services / 297606-01

**Outcome Measure Description:**

DY2 will focus on the Process Milestones necessary to establish and test the system prior to measuring number of successful interventions for the patients and cost avoidance for the program.

**DY2 Process Milestones:**
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
P-3 Develop and test data systems

**DY3 Process Milestones:**
P-2 Establish baseline rates – of projected ED use by target population encountered.

P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

**DY4 and DY5 Outcome Improvement Target**

IT-9.2: ED Appropriate Utilization / Reduce ED use in target population managed by the Community Paramedic Program.

**Rationale:**

The process milestones were selected to establish a Community Paramedic Program in Fort Bend County. The project will involve coordination of several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county, particularly those who inappropriately or repeatedly use high cost medical resources for non-urgent or chronic conditions. The planning stage and development of a data system will be the focus of DY2. During DY3, the project will be implemented and as patients are identified and managed by the program, baseline data, which is not currently available on the population will be gathered. At the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved.

The focus of DY4 and DY5 will be to continue the program as designed or modified and measure the outcome changes for the target population in terms of use of the ED. Target changes for this outcome were developed from similar program outcomes in other locations.
**Outcome Measure Valuation:**
Outcome valuation follows the same process as for the program metrics. Cost avoidance of EMS transport, ED visits and in-patient stays for the county indigent program will be attained if the established targets are met. The total cost avoidance value anticipated for the related category 2 project is $1.4 million. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $750,000.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Process Milestone 3 [P-2]: Establish baseline rates – of projected ED use by target population encountered.</th>
<th>Outcome Improvement Target 1 [IT-9.2]: ED Appropriate Utilization (Reduce ED use in target population managed by the Community Paramedic Program)</th>
<th>Outcome Improvement Target 1 [IT-9.2]: ED Appropriate Utilization (Reduce ED use in target population managed by the Community Paramedic Program)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Documentation of activities and plans</td>
<td>Data Source: EHR, ePCR</td>
<td>Baseline/Goal: DY 3 ED projected use for target population / Improvement Target:25% reduction from baseline</td>
<td>Baseline/Goal: DY 3 ED use for target population / Improvement Target:30% reduction from baseline</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $1,931</td>
<td>Process Milestone 3 Estimated Incentive Payment: $3,050</td>
<td>Data Source: ePCR, EHR</td>
<td>Data Source: ePCR, EHR</td>
</tr>
<tr>
<td>Process Milestone 2 [P-3]: Develop and test data systems</td>
<td>Process Milestone 4 [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $9,902</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $21,449</td>
</tr>
<tr>
<td>Data Source: Documentation of systems and results of tests</td>
<td>Data Source: PDSA data and actions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $1,931</td>
<td>Process Milestone 3 Estimated Incentive Payment: $3,050</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2 Estimated Outcome Amount:** $3,862  
**Year 3 Estimated Outcome Amount:** $9,150  
**Year 4 Estimated Outcome Amount:** $9,902  
**Year 5 Estimated Outcome Amount:** $21,449  
**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $44,363
**Title of Outcome Measure (Improvement Target):** IT 9.4 – Other Outcome Improvement
Target / Reduce EMS transport use in target population managed by the Community Paramedic Program

**Unique RHP Outcome Identification Number:** 2967606-01 3.7 / Pass 2

**Performing Provider:** Fort Bend County Clinical Health Services / 297606-01

**Outcome Measure Description:**

DY2 will focus on the Process Milestones necessary to establish and test the system prior to measuring number of successful interventions for the patients and cost avoidance for the program.

**DY2 Process Milestones:**
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
P-3 Develop and test data systems

**DY3 Process Milestones:**
P-2 Establish baseline rates – of projected ED use by target population encountered.
P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

**DY4 and DY5 Outcome Improvement Target**
IT-9.2: ED Appropriate Utilization / Reduce EMS transport use in target population managed by the Community Paramedic Program.

**Rationale:**

The process milestones were selected to establish a Community Paramedic Program in Fort Bend County. The project will involve coordination of several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county, particularly those who inappropriately or repeatedly use high cost medical resources for non-urgent or chronic conditions. The planning stage and development of a data system will be the focus of DY2. During DY3, the project will be implemented and as patients are identified and managed by the program, baseline data, which is not currently available on the population will be gathered. At the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved. The focus of DY4 and DY5 will be to continue the program as designed or modified and measure the outcome changes for the target population in terms of use of the ED. Target changes for this outcome were developed from similar program outcomes in other locations.
**Outcome Measure Valuation:**
Outcome valuation follows the same process as for the program metrics. Cost avoidance of EMS transport, ED visits and in-patient stays for the county indigent program will be attained if the established targets are met. The total cost avoidance value anticipated for the related category 2 project is $1.4 million. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $750,000.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  Data Source: Documentation of activities and plans  Process Milestone 1 Estimated Incentive Payment (maximum amount): $1,931</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 2 [P-3]: Develop and test data systems  Data Source: Documentation of systems and results of tests  Process Milestone 2 Estimated Incentive Payment: $1,931</td>
</tr>
<tr>
<td>Process Milestone 3 [P-2]: Establish baseline rates – of projected EMS transport use by target population encountered.  Data Source: EHR, ePCR  Process Milestone 3 Estimated Incentive Payment: $3,050</td>
</tr>
<tr>
<td>Process Milestone 4 [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.  Data Source: PDSA data and actions  Process Milestone 4 Estimated Incentive Payment: $3,050</td>
</tr>
<tr>
<td>Process Milestone 5 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders  Data Source: Reports provided  Process Milestone 5 Estimated Incentive Payment: $3,050</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 [IT-9.4]: Other outcome improvement target / Reduce EMS transport use in target population managed by the Community Paramedic Program  Baseline/Goal: DY3 EMS transport use for the target population / Improvement Target:25% reduction from baseline  Data Source: ePCR, EHR  Outcome Improvement Target 1 Estimated Incentive Payment: $9,902</td>
</tr>
<tr>
<td>Outcome Improvement Target 2 [IT-9.4]: Other outcome improvement target / Reduce EMS transport use in target population managed by the Community Paramedic Program  Baseline/Goal: DY3 EMS transport use for the target population / Improvement Target:30% reduction from baseline  Data Source: ePCR, EHR  Outcome Improvement Target 2 Estimated Incentive Payment: $21,449</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5)*: $44,363
Title of Outcome Measure (Improvement Target): IT-6.1 Patient Experience with Access to Specialist, Shared Decision Making

Unique RHP Outcome Identification Number: 2967606-01 3.8 / Pass 2
Performing Provider: Fort Bend County Clinical Health Services / 297606-01

Outcome Measure Description:
DY2 and part of DY3 will focus on the Process Milestones and baseline data gathering necessary to establish and test the system prior to measuring patient satisfaction with the increased screenings and access to specialty care.

DY2 Process Milestones:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
P-3 Develop and test data systems

DY3 Process Milestones:
P-2 Establish baseline rates of colonoscopy screening in the targeted population.
P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

DY4 and DY5 Outcome Improvement Target:
IT-6.1: Patient Experience with Access to Specialist, Shared Decision Making

Rationale:
The process milestones were selected to help establish a colonoscopy screening program for the prevention and early detection of colorectal cancer. The project will involve coordination of several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county. The planning stage and development of a data system will be the focus of DY2.

The outcome measure of patient satisfaction was selected to determine the acceptance and satisfaction of the program in the targeted population. Baseline experience with access to specialists and shared decision making using the CG-CAHPS survey will be undertaken for the target population in DY2. During DY3, the project will be implemented, and at the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved. The focus of DY4 and DY5 will be to continue the program as designed or modified and measure the experience of the target population after program implementation.

Outcome Measure Valuation:
Outcome valuation follows the same process as for the program metrics. Cost avoidance of colorectal cancer treatment costs for the county indigent program if the established targets are
met, to be replaced by the lower cost colonoscopy screening and cancer prevention procedures. The total cost avoidance value anticipated for the related category 2 project 2967606-01 2.2 is $660,000. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $539,044.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>2967606-01 2.4</th>
<th>2967606-01 3.8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
<td>$20,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 5 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders. Data Source: Reports provided. Process Milestone 5 Estimated Incentive Payment: $3,288.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Improvement Target 1 [IT-6.1]: Increased patient satisfaction with their experience with access to specialist and with shared decision making. Baseline / Goal: DY2 baseline / Improvement Target: 20% increase from baseline. Data Source: EHR, survey. Outcome Improvement Target 1 Estimated Incentive Payment: $7,116.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome Improvement Target 2 [IT-6.1]: Increased patient satisfaction with their experience with access to specialist and with shared decision making. Baseline / Goal: DY2 baseline / Improvement Target: 40% increase from baseline. Data Source: EHR, survey. Outcome Improvement Target 1 Estimated Incentive Payment: $15,416.</td>
</tr>
<tr>
<td>Project ID</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>2967606-01 3.8</td>
</tr>
<tr>
<td>2967606-01 2.4</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $31,884
Title of Outcome Measure (Improvement Target): IT 12.3 – Colorectal Cancer Screening

Unique RHP Outcome Identification Number: 2967606-01 3.9 / Pass 2

Performing Provider: Fort Bend County Clinical Health Services / 297606-01

Outcome Measure Description:

DY2 and part of DY3 will focus on the Process Milestones necessary to establish and test the system prior to measuring increased screening and results for the patients and cost avoidance for the program.

DY2 Process Milestones:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
P-3 Develop and test data systems
P-2 Establish Baseline Rates of Colonoscopy Screening in the target population

DY3 Process Milestones:
P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

DY3 Outcome Improvement Target:
IT 12.3 – Colorectal Cancer Screening

DY4 and DY5 Outcome Improvement Target:
IT 12.3 – Colorectal Cancer Screening

Rationale:

The process milestones were selected to help expand a new program of colorectal cancer screening in the uninsured and underinsured population of Fort Bend County. The project will involve coordination of several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county. The planning stage and development of a data system will be the focus of DY2, and rates of colonoscopy screening in the population will be measured. The program will be implemented in DY3. At the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved.

The focus of DY4 and DY5 will be to continue the program as designed or modified and measure the outcome change for the target population. The outcome measure is the proportion of the target population screened for colorectal cancer using a colonoscopy.
**Outcome Measure Valuation:**
Outcome valuation follows the same process as for the program metrics. Cost avoidance of colorectal cancer treatment costs for the county indigent program if the established targets are met, to be replaced by the lower cost colonoscopy screening and cancer prevention procedures. The total cost avoidance value anticipated for the related category 2 project 2967606-01 2.2 is $600,000. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of 539,044.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Documentation of activities and plans</td>
<td><strong>Process Milestone 4 [P-4]:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: PDSA data and actions</td>
<td><strong>Outcome Improvement Target 2</strong> [IT-12.3]: Colorectal Cancer Screening Baseline / Goal: DY2 baseline / Improvement Target: 50% increase from baseline Data Source: EHR, records of referrals and appointments</td>
<td><strong>Outcome Improvement Target 3</strong> [IT-12.3]: Colorectal Cancer Screening Baseline / Goal: DY2 baseline / Improvement Target: 100% increase from baseline Data Source: EHR, records of referrals and appointments</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $925</td>
<td>Process Milestone 4 Estimated Incentive Payment: $2,192</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $7,116</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $15,416</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]:</strong> Develop and test data systems Data Source: Documentation of systems and results of tests</td>
<td><strong>Process Milestone 5 [P-5]:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports provided</td>
<td><strong>Outcome Improvement Target 1</strong> [IT-12.3]: Colorectal Cancer Screening Baseline / Goal: DY2 baseline / Improvement Target: 25% increase from baseline Data Source: EHR, records of referrals and appointments</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $925</td>
<td>Process Milestone 5 Estimated Incentive Payment: $2,192</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $2,192</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 3 [P-2]:</strong> Establish baseline rates of colonoscopy screening in the targeted population. Data Source: EHR, survey</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $925</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Outcome Improvement Target 1 [IT-12.3]: Colorectal Cancer Screening Baseline / Goal: DY2 baseline / Improvement Target: 25% increase from baseline Data Source: EHR, records of referrals and appointments
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>2967606-01 2.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $2,776</td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount: $6,576</td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td></td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount: $7,116</td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount: $15,416</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $44,363
Fort Bend County Clinical Health Services
Pass 3
**Title of Outcome Measure (Improvement Target):** OD-1 – Primary Care and Chronic Disease Management / IT 1.1 – Third Next Available Appointment

**Unique RHP Outcome Identification Number:** 2967606-01 3.10

**Performing Provider Name/TPI:** Fort Bend County Clinical Health Services/ 2967606-01

**Outcome Measure Description:**
DY2 and DY3 will focus on the Process Milestones necessary to establish and test the system prior to measuring access outcomes for the patients and cost avoidance for the program.

**DY2 Process Milestones:**
- P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P-3 Develop and test data systems

**DY3 Process Milestones:**
- P-2 Establish baseline rates – of third next available appointment for the target population.
- P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

**DY4 and DY5 Outcome Improvement Target**
- IT-1.1: Third Next Available Appointment

**Rationale:**
The process milestones were selected to help expand the hours of operation within the local FQHC. The project will involve staffing a new care team of medical providers and support staff to allow for standard 7am to 7pm hours on weekdays and to include Saturday hours. Promotion of the hours and referral for use will take coordination with several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county, particularly those patients who inappropriately or repeatedly use high cost medical resources for non-urgent or chronic conditions that could better be managed in a medical home on an outpatient basis with effective care coordination and other resource provision. It is expected that in the first year of implementation the new patient care team will see 65% of the current patient load of a full time provider panel (care team), therefore seeing 975 patients in DY3. In DY4 and DY5, it is anticipated that the new care team will see 1,500 patients each year. The planning stage and development of a data system will be the focus of DY2. During DY3, the project will be implemented and as patients are identified and referred to the program, baseline data, which is not currently available on the population will be gathered. At the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved.

The focus of DY4 and DY5 will be to continue the expanded hours as initiated in DY3 and to measure the change for the target population in terms of third next available appointment.

**Outcome Measure Valuation:**
Outcome valuation follows the same process as for the program metrics. Cost avoidance of EMS transport, ED visits and in-patient stays for the county indigent program if the established targets are met, to be replaced by the lower cost Care Coordination at the FQHC. The total cost avoidance value anticipated for the related category 1 project 2967606-01 1.2 is $2,195,200.
This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $2,100,000. $1,855,899 of the total maximum payment is distributed to the category 1 project 2967606-01 1.2. The remaining $249,101 of the maximum payment is distributed evenly among the 3 outcome measure improvement targets (IT-1.1, and IT-9.2).
| Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans | Process Milestone 3 [P-2]: Establish baseline rates – of third next available appointment. Data Source: EHR, ePCR | Outcome Improvement Target 1 [IT-1.1]: Third next available appointment( Reduce average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam) Baseline/Goal: DY 3 third next available appointment for target population / Improvement Target:10% reduction from baseline (DY3) Data Source: ePCR, EHR | Outcome Improvement Target 1 [IT-1.1]: Third next available appointment( Reduce average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam) Baseline/Goal: DY 3 third next available appointment for target population / Improvement Target:20% reduction from baseline (DY3) Data Source: ePCR, EHR |
| Process Milestone 2 [P-3]: Develop and test data systems Data Source: Documentation of systems and results of tests | Process Milestone 3 Estimated Incentive Payment: $8,517 | Outcome Improvement Target 1 Estimated Incentive Payment: $27,920 | Outcome Improvement Target 1 Estimated Incentive Payment: $60,422 |
| Process Milestone 3 [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: PDSA data and actions | Process Milestone 3 Estimated Incentive Payment: $8,516 | Process Milestone 5 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports provided | Process Milestone 3 Estimated Incentive Payment: $8,516 |
| Process Milestone 2 Estimated Incentive Payment: $5,330 | Process Milestone 3 Estimated Incentive Payment: $8,516 | Process Milestone 5 Estimated Incentive Payment: $8,516 | Process Milestone 5 Estimated Incentive Payment: $8,516 |
| Year 2 Estimated Outcome Amount: $10,661 | Year 3 Estimated Outcome Amount: $25,549 | Year 4 Estimated Outcome Amount: $27,920 | Year 5 Estimated Outcome Amount: $60,422 |
| **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $124,552 |
Title of Outcome Measure (Improvement Target): OD-9 Right Care, Right Setting - IT 9.2 – ED Appropriate Utilization / Reduce ED use in target population referred to Care Coordination Program

Unique RHP Outcome Identification Number: 2967606-01 3.11
Perfoming Provider Name/TP: Fort Bend County Clinical Health Services/2967606-01

Outcome Measure Description:
DY2 and DY3 will focus on the Process Milestones necessary to establish and test the system prior to measuring health outcomes for the patients and cost avoidance for the program.

DY2 Process Milestones:
- P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P-3 Develop and test data systems

DY3 Process Milestones:
- P-2 Establish baseline rates – of ED use by target population encountered and referred.
- P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

DY4 and DY5 Outcome Improvement Target
- IT-9.2: ED Appropriate Utilization / Reduce ED use in target population referred to Care Coordination Program

Rationale:
The process milestones were selected to help expand the hours of operation within the local FQHC. The project will involve staffing a new care team of medical providers and support staff to allow for standard 7am to 7pm hours on weekdays and to include Saturday hours. Promotion of the hours and referral for use will take coordination with several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county, particularly those patients who inappropriately or repeatedly use high cost medical resources for non-urgent or chronic conditions that could better be managed in a medical home on an outpatient basis with effective care coordination and other resource provision. It is expected that in the first year of implementation the new patient care team will see 65% of the current patient load of a full time provider panel (care team), therefore seeing 975 patients in DY3. In DY4 and DY5, it is anticipated that the new care team will see 1,500 patients each year. The planning stage and development of a data system will be the focus of DY2. During DY3, the project will be implemented and as patients are identified and referred to the program, baseline data, which is not currently available on the population, will be gathered. At the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved.

The focus of DY4 and DY5 will be to continue the expanded hours as initiated in DY3 and to measure the change for the target population in terms of use of the ED. Target changes for this outcome were developed from similar program outcomes in other locations.

Outcome Measure Valuation:
Outcome valuation follows the same process as for the program metrics. Cost avoidance of EMS transport, ED visits and in-patient stays for the county indigent program if the established targets
are met, to be replaced by the lower cost Care Coordination at the FQHC. The total cost avoidance value anticipated for the related category 1 project 2967606-01 1.2 is $2,195,200. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $2,100,000. $1,855,899 of the total maximum payment is distributed to the category 1 project 2967606-01 1.2. The remaining $249,101 of the maximum payment is distributed evenly among the 3 outcome measure improvement targets (IT-1.1, and IT-9.2).
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
| **Process Milestone 1** [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
Data Source: Documentation of activities and plans | **Process Milestone 3** [P-2]: Establish baseline rates – of ED use by target population encountered and referred.  
Data Source: EHR, ePCR | **Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization (Reduce ED use in target population after establishment of expanded clinic hours)  
Baseline/Goal: DY 3 ED use for target population / Improvement Target: 25% reduction from baseline  
Data Source: ePCR, EHR | **Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization (Reduce ED use in target population after establishment of expanded clinic hours)  
Baseline/Goal: DY 3 ED use for target population / Improvement Target: 30% reduction from baseline  
Data Source: ePCR, EHR |
| Process Milestone 1 Estimated Incentive Payment (*maximum amount*): $5,330 | Process Milestone 3 Estimated Incentive Payment: $8,517 | Outcome Improvement Target 1 Estimated Incentive Payment: $27,919 | Outcome Improvement Target 1 Estimated Incentive Payment: $60,421 |
| **Process Milestone 2** [P-3]: Develop and test data systems  
Data Source: Documentation of systems and results of tests | **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.  
Data Source: PDSA data and actions | | |
| Process Milestone 2 Estimated Incentive Payment: $5,330 | Process Milestone 3 Estimated Incentive Payment: $8,516 | | |
| **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders  
Data Source: Reports provided | | | |
| | Process Milestone 3 Estimated Incentive Payment: $8,516 | | |

**Year 2 Estimated Outcome Amount:** $10,660  
**Year 3 Estimated Outcome Amount:** $25,549  
**Year 4 Estimated Outcome Amount:** $27,919  
**Year 5 Estimated Outcome Amount:** $60,421

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $124,549
Gulf Bend
Pass 2
Title of Outcome Measure (Improvement Target):
OD-2 Potentially Preventable Admissions, IT-2.4 Behavioral Health/Substance Abuse Admission Rate

Unique RHP outcome identification number: 1352544-07.3.1/Pass 2
Performing provider/TPI: Gulf Bend Center/135254407

Outcome Measure Description:
The related Category 3 outcome improvement measure chosen for the Gulf Bend Person-Centered Behavioral Health Medical Home project is OD-2 Potentially Preventable Admissions, specifically IT-2.4 Behavioral Health/Substance Abuse Admission Rate including the following:
   1. One for BH/SA as the principal diagnosis
   2. A second category in which a significant BH/SA secondary diagnosis is present (e.g. reduction in admission rate with a primary diagnosis of asthma/diabetes/COPD with a secondary diagnosis of mood/affective disorders.

Through this project Gulf Bend expects to decrease admissions due to asthma, depression, and diabetes with an underlying or co-existing mental health disorder by 25% by the end of DY 5.

Outcome Improvement Targets for each year:

Rationale:
Process milestones P-1 through P-3 were chosen so we can establish a detailed project plan including identifying current capacity and needed resources and baseline information in which to effectively manage and monitor the project. Gulf Bend expects to see a decrease in the admission rates as described above by developing and implementing the Person-Centered Behavioral Health Medical Home. Targeting at risk populations with co-morbid diseases of mental illness and chronic disease who currently go untreated or under treated and who routinely access more intensive and costly services such as emergency departments, inpatient hospitals or jails and through this outcome measure we expect to see the success of a reduction in hospital admissions with a primary diagnosis of chronic disease and a secondary diagnosis of behavioral health.

Outcome Measure Valuation:
Due to the high number of admissions to the local hospitals due to co-occurring mood/affective disorders and chronic co-morbid disease, Gulf Bend feels that an initial decrease for all three admissions by 25% by the end of DY 5 is a great starting point. This could lead to an overall savings of $3,249,179 in just one year. These numbers may seem low, but this is because the integration of primary care and behavioral health services is new to the area. It will take time for patients to take full advantage of the integrated services offered by Gulf Bend.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>1352544-07.2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Behavioral Health Admission rate with co-occurring chronic disease</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong> P-1 Project planning- engage stakeholders, identify current capacity and need resources, determine timelines and document implementation plans</td>
<td></td>
</tr>
<tr>
<td><strong>Baseline/Goal:</strong> 54 admissions due to COPD, and 48 admissions due to diabetes with roughly 29% of each patient population having a co-occurring mental illness or behavioral health illness</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Encounter data, claims, hospital records</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong> P-2 Establish baseline rates</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Encounter data, claims, hospital records</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1</strong> IT-2.4 Reduction in hospital admissions with primary diagnosis of chronic disease and secondary diagnosis of behavioral health by 10%</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Hospital EHR records, discharge data</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $50,000</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $100,000</td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan Region 3 1854
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>1352544-07.2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Behavioral Health Admission rate with co-occurring chronic disease</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $450,000
Gulf Coast Medical Center
Pass 1
**Title of Outcome Measure (Improvement Target):** IT-1.18 Follow up after Hospitalization for Mental Illness-NFQ 0576

**Performing Provider Name/TPI:** Gulf Coast Medical Center/178815001

**Unique RHP Outcome Identification Number:** 178815001.3.1

**Outcome Measure Description:**

IT-1.18

- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge.
- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge.

**Process Milestones:**

- DY 2: P-1; P-2; P-3
- DY 3: P-5

**Outcome Improvement Target(s) for each Year:**

- DY 4
  - IT-1.18 Increase in percentage of patients with follow up care after hospitalization for Mental Illness
    - Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge.
    - Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge.

- DY 5
  - IT-1.18 Increase in percentage of patients with follow up care after hospitalization for Mental Illness
    - Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge.
    - Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge.

**Rationale:**

Process Milestone P-1, P-2 and P-3 were chosen to establish a foundation for the establishment of an inpatient adult psychiatric unit and consideration for an outpatient center for follow up care. The focus was to ensure that an initial timely response to a potential need for psychiatric care was addressed. Delay in treatment in the care of an individual with mental illness may result in adverse outcomes. During DY 2 a baseline will be established and DY 3, 4, and 5 has a percentage increase annually to complete admission process from time of referral to arrival on unit.
Improvement targets were placed in DY 3, DY 4 and DY 5 based upon the timeframe allowed to put in place the proper education/training and process implementation. Although all the overall goal is to ensure that individuals within the county, and surrounding counties and the military have expedited access to mental health care and receive quality inpatient care for the treatment of mental disorders it is of utmost importance that when patients move to the next continuum (discharge) treatment continues on an outpatient basis to ensure compliance with the treatment plan thus preventing readmissions. Patients in the project will need to be followed over time. Based upon the need to ensure compliance on an outpatient basis regarding the treatment plan established for the patient while hospitalized, follow up after hospitalization for mental illness is a targeted improvement outcome.

**Outcome Measure Valuation:**
Areas considered when allocating funds for this project included the importance of ensuring individuals within Wharton County and the surrounding rural areas, with a large underserved/underinsured population, access to the care needed with regard to mental disorders. Upon discharge from an inpatient psychiatric facility follow up care by a mental health practitioner is of utmost importance to ensure that the patient remains compliant with his/her treatment plan to ensure a positive outcome with their care and reduce preventable readmissions. An enhanced continuing care plan with linkages to the next level of care post-discharge will result in overall reductions in healthcare costs.
**Follow up after Hospitalization for Mental Illness NGQ 0576**

- **Gulf Coast Medical Center**
- **178815001**

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>178815001.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>TBD</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan.</td>
<td><strong>Process Milestone 2</strong> [P-2]: Establish baselines.</td>
</tr>
<tr>
<td>Data Source: Potential management company documentation, AIA architect</td>
<td>Data Source: Claims, EHR</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $56,716.67</td>
<td>Process Milestone 2 Estimated Incentive Payment: $56,716.67</td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1</strong> [IT-1.18]: Follow up After Hospitalization for Mental Illness Improvement Target: Establish baseline rate for follow up with mental health practitioner within 30 days (rate 1) and within 7 days (rate2) after hospitalization. Data Source: Reports and hospital generated data.</td>
<td><strong>Outcome Improvement Target 2</strong> Estimated Incentive Payment: $68,785.50</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $170,150</td>
<td>Year 3 Estimated Outcome Amount: $137,571</td>
</tr>
</tbody>
</table>

**Region 3**

**Regional Healthcare Partnership Plan**

- **1859**
## Follow up after Hospitalization for Mental Illness NGQ 0576

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>178815001.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $823,217*
Title of Outcome Measure (Improvement Target):  IT-1.20 Timeliness of Inpatient Admission for Mental Illness

Performing Provider Name/TPI:  Gulf Coast Medical Center/178815001

Unique RHP Outcome Identification Number:  178815001.3.2

Outcome Measure Description:

IT-1.20

- Timely admission to Inpatient Psychiatric Unit—based upon systems and processes instituted at the time of the establishment of the adult inpatient psychiatric timely respond to referrals for inpatient treatment will be measured and targets set to improve response rates.

Process Milestones:

- DY 2: P-1; P-2, P-3
- DY 3: P-3

Outcome Improvement Target(s) for each Year:

- DY 4
  - Improve rate for DY 4 as compared to baseline rate established in DY 2. Increase admission rate by 5%.
- DY 5
  - Improve rate for DY 5 as compared to baseline rate established in DY 2. Increase patient rate to by 8%.

Rationale:

Process Milestone P-1, P-2 and P-3 were chosen to establish a foundation for the establishment of an inpatient adult psychiatric unit and consideration for an outpatient center for follow up care. The focus was to ensure that an initial timely response to a potential need for psychiatric care was addressed. Delay in treatment in the care of an individual with mental illness may result in adverse outcomes. During DY 2 a baseline will be established and DY 3, 4, and 5 has a percentage increase annually to complete admission process from time of referral to arrival on unit.

Improvement targets were placed in DY 3, DY 4 and DY 5 based upon the timeframe allowed to put in place the proper education/training and process implementation. Although all the overall goal is to ensure that individuals within the county, surrounding counties and the military have expedited access to mental health care and receive quality inpatient care for the treatment of mental disorders it is of utmost importance that when patients move to the next continuum (discharge) treatment continues on an outpatient basis to ensure compliance with the treatment plan thus preventing readmissions. Patients in the project will need to be followed over time. Based upon the need to ensure compliance on an outpatient basis regarding the treatment plan established for the patient while hospitalized, follow up after hospitalization for mental illness is a targeted improvement outcome.
**Outcome Measure Valuation:**

Areas considered when allocating funds for this project included the importance of ensuring individuals within Wharton County and the surrounding rural areas with a large underserved/underinsured population, access to the care needed with regard to mental disorders. A 28 bed inpatient adult psychiatric unit would allow individual’s timely access to care for mental disorders whereas currently delays as long as up to 60 hours before receiving in care is experienced frequently as bed availability is limited and waiting lists for beds are being utilized. With Gulf Coast Medical Center expanding the presence of psychiatric care to improve access to care for the vastly underserved area; growth and patient impact could be substantial. With robust ongoing enhancement the adult psychiatric services could expand from a baseline of virtually zero local behavioral health impatient services for adults to potentially directly impacting 760 persons with mental disorders per year though the life of this demonstration project. The elements of access to care and patient satisfaction (as measured by patient satisfaction surveys), as well as clinical outcomes (as measured by admission and discharge DLS-20 scores) are bound to improve significantly once the adult psychiatric unit is operational. The time between referral to admission onto a psychiatric service unit could be reduced dramatically with immediate access; from the current possible 60 hours to less than 24 hours.
### Related Category 1 or 2 Projects:

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plan.</td>
<td><strong>Process Milestone 4</strong> [P-5]: Disseminate findings including lessons learned and best practices to stakeholders. Data Source: Documented findings.</td>
<td><strong>Outcome Improvement Target 2</strong> [IT 1.20]: Timely Admission to Inpatient Psychiatric Unit Baseline/Goal: DY 2 Improvement Target: Improve rate for DY 4 to be 25% better as compared to baseline rate established in DY2. Increase patient admission rate to an average daily census -TBD. Data Source: Reports and hospital generated data</td>
<td><strong>Outcome Improvement Target 3</strong> [IT 1.20]: Timely Admission to Inpatient Psychiatric Unit Baseline/Goal: DY 2 Improvement Target: Improve rate for DY 5 to be 40% better as compared to baseline rate established in DY2. Increase patient admission rate to an average daily census -TBD. Data Source: Reports and hospital generated data</td>
</tr>
<tr>
<td>Data Source: Potential management company documentation, AIA architect</td>
<td>Estimated Incentive Payment: $20,000</td>
<td>Outcome Improvement Target 2 Incentive Payment: $200,000</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $300,000</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $54,738</td>
<td><strong>Outcome Improvement Target 1</strong> [IT 1.20]: Timely Admission to Inpatient Psychiatric Unit Baseline/Goal: DY 2 baseline/Improvement Target: Improve rate for DY 3 to be 10% better as compared to baseline rate established in DY2. Data Source: Reports and hospital generated data</td>
<td><strong>Outcome Improvement Target 2</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong> [P-2]: Establish baselines. Data Source: Claims, EHR</td>
<td>Process Milestone 2 Estimated Incentive Payment: $54,738</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 3</strong> [P-3]: Develop and test systems. Data Source: Data systems</td>
<td>Milestone 3 Estimated Incentive Payment: $54,738</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $150,000</td>
<td></td>
</tr>
</tbody>
</table>

**Outcome Improvement Target 1**
- **Baseline/Goal**: DY 2
- **Improvement Target**: Improve rate for DY 3 to be 10% better as compared to baseline rate established in DY2.
- **Data Source**: Reports and hospital generated data
- **Incentive Payment**: $150,000

**Outcome Improvement Target 2**
- **Baseline/Goal**: DY 2
- **Improvement Target**: Improve rate for DY 4 to be 25% better as compared to baseline rate established in DY2. Increase patient admission rate to an average daily census -TBD.
- **Data Source**: Reports and hospital generated data
- **Incentive Payment**: $200,000

**Outcome Improvement Target 3**
- **Baseline/Goal**: DY 2
- **Improvement Target**: Improve rate for DY 5 to be 40% better as compared to baseline rate established in DY2. Increase patient admission rate to an average daily census -TBD.
- **Data Source**: Reports and hospital generated data
- **Incentive Payment**: $300,000
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>178815001.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $164,214</td>
<td>Year 3 Estimated Outcome Amount: $170,000</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $834,214
Harris County Hospital District Ben Taub General Hospital
Pass 1
Title of Outcome Measure (Improvement Target): IT 6.2- Other: Percent improvement over baseline of Patient Satisfaction scores

Unique RHP outcome identification number(s): 133355104.3.1
Performing Provider Name/TPI: Harris Health System / 133355104

Outcome Measure Description:
IT 6.2 will measure improvement in the overall mean score for patient satisfaction over time using the standard same day access clinic survey supplied by Press Ganey and approved by HHSC.

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For the Gulfgate Health Center, there were 792 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. As a result, patient satisfaction scores reported by Press Ganey can be greatly improved. From November 2011-October 2012 at Gulfgate Health Center, the mean score for “Ease of scheduling appointments” was 68.0.

Same day access clinic operations will differ from current health centers, resulting in a need for a customized survey. The baseline patient satisfaction score at Gulfgate same day access clinic will be established in DY3 after a new, custom survey is developed and implemented through Press Ganey for same day access clinic usage.

Process Milestones:
- DY2: P-1; P-5
- DY3: P-2; P-4

Outcome Improvement Target(s) for each year:
- DY4:
  - IT 6.2- 0.5% improvement over baseline of patient satisfaction for overall mean survey score
- DY5:
  - IT 6.2- 1% improvement over baseline of patient satisfaction for overall mean survey score

Rationale:
P-1 was chosen to ensure that all necessary stakeholders are consulted to develop strategies and processes necessary to reach patient satisfaction goals. Moreover, a new, customized patient satisfaction survey will be developed for same day access clinics in partnership with Press Ganey. P-5 will also be approached in DY2. We plan to share finding and lessons from project planning with internal and external stakeholders. In DY3, P-2 will produce a baseline score at the new clinic based on available performance. In DY3, we will also conduct
PDSA cycles for P-4 to ensure that strategies and processes for identified interventions are effective.

IT- 6.2 will be measured beginning in DY4 to allow for time and resources needed to purchase lease space, hire staff, and operate the same day access clinic for patient care and successful survey calculation. Improvement targets were chosen with the expectation to reach patient satisfaction goals gradually to coincide with improvements in operations at the clinic. Based on Harris Health System’s historic Press Ganey patient satisfaction scores and the volume of patients served, we believe the percent improvement goals suggested are both challenging and meaningful.

**Outcome Measure Valuation:**

This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic’s capacity to provide primary care services, including laboratory point-of-care testing, along with timely referrals for specialty care, imaging and other needed services within the Harris Health System network. The clinic can ultimately care for the episodic primary care needs of over ten thousand patients annually, and refer new patients with chronic disease management needs to one of the NCQA certified medical home clinics that are operated by Harris Health. In addition, the availability of same day primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

Currently, some patients do not rate Harris Health positively due to the fact that waitlists to see providers are at times sixty plus days because of the high demand and limited providers. Because of the current back-log of patients, Harris Health System assures that by building a Casa de Amigos Same Day Access clinic, we will meet the basic needs of thousands of more patients in a timely manner, giving Harris Health the ability to survey potentially 31,000 additional patients between DY3 and DY5, increasing the patient satisfaction score. From 2011 to 2012, Harris Health System’s existing Ambulatory Care Health Centers patient satisfaction score improved 2% across all centers combined, leading us to believe that the goals we have established will be both challenging and meaningful upon establishing a baseline. For this project, Harris Health will implement a new survey tool for a different environment in which care will be provided; therefore, we wanted to keep the goals achievable as this will be a new endeavor for our system in terms of same day clinics and patient satisfaction.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133355104.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be established in DY3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 3</strong> [P-2]: Establish baseline patient satisfaction score at Gulfgate same day access clinic</td>
<td><strong>Outcome Improvement Target 1</strong> [IT-6.2]: Percent improvement over baseline of patient satisfaction Improvement Target: Increase score by 0.5% above baseline</td>
<td><strong>Outcome Improvement Target 2</strong> [IT-6.2]: Percent improvement over baseline of patient satisfaction Improvement Target: Increase score by 1% above baseline</td>
</tr>
<tr>
<td>Data Source: EHR; Business Intelligence</td>
<td>Data Source: Press Ganey</td>
<td>Data Source: Press Ganey</td>
<td>Data Source: Press Ganey</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $419,558</td>
<td>Process Milestone 3 Estimated Incentive Payment: $486,323</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $1,560,756</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $3,732,243</td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong> [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Process Milestone 4</strong> [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve intervention activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR; Business Intelligence; reports</td>
<td>Data Source: Report documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $419,558</td>
<td>Process Milestone 4 Estimated Incentive Payment (maximum amount): $486,322</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $839,116</td>
<td>Year 3 Estimated Outcome Amount: $972,645</td>
<td>Year 4 Estimated Outcome Amount: $1,560,756</td>
<td>Year 5 Estimated Outcome Amount: $3,732,243</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $7,104,760
**Title of Outcome Measure (Improvement Target):** IT 6.2- Other: Percent improvement over baseline of Patient Satisfaction scores

**Unique RHP outcome identification number(s):** 133355104.3.2

**Performing Provider Name/TPI:** Harris Health System / 133355104

**Outcome Measure Description:**

IT 6.2 will measure improvement in the overall mean score for patient satisfaction over time using the standard same day access clinic survey supplied by Press Ganey and approved by HHSC.

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health health centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For the People’s health center, there were 465 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. As a result, patient satisfaction scores reported by Press Ganey can be greatly improved. From November 2011-October 2012 at People’s Health Center, the mean score for “Ease of scheduling appointments” was 68.9.

Same day access clinic operations will differ from current health centers, resulting in a need for a customized survey. The baseline patient satisfaction score at People’s same day access clinic will be established in DY3 after a new, custom survey is developed and implemented through Press Ganey for same day access clinic usage.

**Process Milestones:**

- DY2: P-1; P-5
- DY3: P-2; P-4

**Outcome Improvement Target(s) for each year:**

- DY4:
  - IT 6.2- 0.5% improvement over baseline of patient satisfaction for overall mean survey score
- DY5:
  - IT 6.2- 1% improvement over baseline of patient satisfaction for overall mean survey score

**Rationale:**

P-1 was chosen to ensure that all necessary stakeholders are consulted to develop strategies and processes necessary to reach patient satisfaction goals. Moreover, a new, customized patient satisfaction survey will be developed for same day access clinics in partnership with Press Ganey. P-5 will also be approached in DY2. We plan to share finding and lessons from project planning with internal and external stakeholders. In DY3, P-2 will produce a
baseline score at the new clinic based on available performance. In DY3, we will also conduct PDSA cycles for P-4 to ensure that strategies and processes for identified interventions are effective.

IT-6.2 will be measured beginning in DY4 to allow for time and resources needed to purchase lease space, hire staff, and operate the same day access clinic for patient care and successful survey calculation. Improvement targets were chosen with the expectation to reach patient satisfaction goals gradually to coincide with improvements in operations at the clinic. Based on Harris Health System’s historic Press Ganey patient satisfaction scores and the volume of patients served, we believe the percent improvement goals suggested are both challenging and meaningful.

**Outcome Measure Valuation:**

This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic’s capacity to provide primary care services, including laboratory point-of-care testing, along with timely referrals for specialty care, imaging and other needed services within the Harris Health System network. The clinic can ultimately care for the episodic primary care needs of over ten thousand patients annually, and refer new patients with chronic disease management needs to one of the NCQA certified medical home clinics that are operated by Harris Health. In addition, the availability of same day primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

Currently, some patients do not rate Harris Health positively due to the fact that waitlists to see providers are at times sixty plus days because of the high demand and limited providers. Because of the current back-log of patients, Harris Health System assures that by building a Casa de Amigos Same Day Access clinic, we will meet the basic needs of thousands of more patients in a timely manner, giving Harris Health the ability to survey potentially 31,000 additional patients between DY3 and DY5, increasing the patient satisfaction score. From 2011 to 2012, Harris Health System’s existing Ambulatory Care Health Centers patient satisfaction score improved 2% across all centers combined, leading us to believe that the goals we have established will be both challenging and meaningful upon establishing a baseline. For this project, Harris Health will implement a new survey tool for a different environment in which care will be provided; therefore, we wanted to keep the goals achievable as this will be a new endeavor for our system in terms of same day clinics and patient satisfaction.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]</strong>: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 3 [P-2]</strong>: Establish baseline patient satisfaction score at People’s same day access clinic</td>
<td><strong>Outcome Improvement Target 1 [IT-6.2]</strong>: Percent improvement over baseline of patient satisfaction Improvement Target: Increase score by 0.5% above baseline Data Source: Press Ganey</td>
<td><strong>Outcome Improvement Target 2 [IT-6.2]</strong>: Percent improvement over baseline of patient satisfaction Improvement Target: Increase score by 1% above baseline Data Source: Press Ganey</td>
</tr>
<tr>
<td>Data Source: EHR; Business Intelligence</td>
<td>Process Milestone 3 Estimated Incentive Payment: $486,323</td>
<td>Process Milestone 3 Estimated Incentive Payment: $486,323</td>
<td>Process Milestone 2 Estimated Incentive Payment: $486,323</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $419,558</td>
<td><strong>Process Milestone 4 [P-4]</strong>: Conduct Plan Do Study Act (PDSA) cycles to improve intervention activities Data Source: Report documentation</td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment</strong>: $1,560,756</td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment</strong>: $3,732,243</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-5]</strong>: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR; Business Intelligence; reports</td>
<td>Process Milestone 4 Estimated Incentive Payment (maximum amount): $486,322</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $1,560,756</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $419,558</td>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $839,116</td>
<td>Year 3 Estimated Outcome Amount: $972,645</td>
<td>Year 4 Estimated Outcome Amount: $1,560,756</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add outcome amounts over DYs 2-5): $7,104,760</td>
<td>Year 5 Estimated Outcome Amount: $3,732,243</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): IT- 6.2: Percent improvement over baseline of patient satisfaction

Unique RHP outcome identification number(s): 133355104.3.3
Performing Provider Name/TPI: Harris Health System /133355104

Outcome Measure Description:
IT- 6.2: will measure percent improvement over baseline of patient satisfaction scores for the Access dimension mean score on the Press Ganey Medical Practice Survey currently used at Harris Health System. The expansion of primary care capacity in the existing Health Centers will increase capacity for primary care visits within the Harris Health System, which will enhance access and improve the patient experience in obtaining services. Patient satisfaction scores for timely access to care for the Health Centers have historically been below expectations. The expansion of primary care capacity in the existing Health Centers will offer additional access, affording patients the opportunity to seek care in the right setting. The current score for Ease of scheduling appointment for the Health Centers is 71.3%. The additional providers will add capacity for appointments, which will increase appointment availability for both new and return patients. The enhanced access to care will result in improved patient satisfaction scores as related Access.

Process Milestones:
- DY2: P-1
- DY3: P-2

Outcome Improvement Target(s) for each year:
- DY4:
  - IT- 6.2: Percent improvement over baseline of patient satisfaction score
    - Increase Access survey dimension score by 0.5% above baseline
- DY5:
  - IT- 6.2: Percent improvement over baseline of patient satisfaction score
    - Increase Access survey dimension score by 1% above baseline

Rationale:
P-1 was chosen to ensure that all necessary stakeholders are involved and addressed to develop the strategies necessary to improve Access to Care patient satisfaction scores. Improvement targets were chosen based on the time and resources needed to hire and train physicians and support staff. The improved patient access may begin in DY3, patient satisfaction score improvements will be measured in DY4 and DY5. Improvement target 1 aims to increase patient satisfaction by 0.5% above baseline, while improvement target 2 aims to increase patient satisfaction by 1% above baseline.

Outcome Measure Valuation:
This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in Harris County. The value of the project is based on the expansion of services in Harris Health System’s NCQA certified medical home clinics, substantially increasing our capacity to provide primary care services, including laboratory testing, imaging, and other ancillary services, along with prescription medications and timely referrals for specialty care and other needed services within the Harris Health System network.
The increase in provider staffing throughout the existing medical home network can ultimately care for the primary care needs of an additional twenty-three thousand patients annually, including the coordination of chronic disease education and management for patients needing those services. In addition, the availability of incremental primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.
### Harris Health System

**IT-6.2**

**IT-6.1 Percent improvement over baseline of patient satisfaction scores**

---

**Related Category 1 or 2 Projects:** 133355104.1.3

---

**Starting Point/Baseline:**

**Year 2** (10/1/2012 – 9/30/2013)

- **Process Milestone 1 [P-1]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - Data Source: EHR; billing system

- **Process Milestone 1 Estimated Incentive Payment (maximum amount):** $1,666,789

**Year 3** (10/1/2013 – 9/30/2014)

- **Process Milestone 2 [P-2]:** Establish baseline Patient Satisfaction Score for Access dimension
  - Data Source: Press Ganey Patient Satisfaction Survey

- **Process Milestone 2 Estimated Incentive Payment:** $1,932,026

**Year 4** (10/1/2014 – 9/30/2015)

- **Outcome Improvement Target 1 [IT-6.1]:** Percent improvement over baseline of patient satisfaction score for Access dimension Improvement Target: Increase Access survey dimension score by 0.5% above baseline
  - Data Source: Press Ganey Medical Practice Survey

- **Outcome Improvement Target 1 Estimated Incentive Payment:** $3,100,227

**Year 5** (10/1/2015 – 9/30/2016)

- **Outcome Improvement Target 2 [IT-6.1]:** Percent improvement over baseline of patient satisfaction score for Access dimension Improvement Target: Increase Access survey dimension score by 1% above baseline
  - Data Source: Press Ganey Medical Practice Survey

- **Outcome Improvement Target 2 Estimated Incentive Payment:** $7,413,587

---

**Year 2 Estimated Outcome Amount:**

- (add incentive payments amounts from each milestone/outcome improvement target): $1,666,789

**Year 3 Estimated Outcome Amount:**

- $1,932,026

**Year 4 Estimated Outcome Amount:**

- $3,100,227

**Year 5 Estimated Outcome Amount:**

- $7,413,587

---

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**

(add outcome amounts over DYs 2-5): $14,112,629

---

Regional Healthcare Partnership Plan

Region 3

1874
Title of Outcome Measure (Improvement Target): IT- 1.10 Diabetes care: HbA1c poor control (>9.0%)

Unique RHP outcome identification number(s): 133355104.3.4
Performing Provider Name/TPI: Harris Health System / 133355104

Outcome Measure Description:
IT1.10 will measure improvement in the percentage of patients 18-75 years of age with poorly controlled diabetes. Poorly controlled will be defined as patients with diabetes (type 1 or 2) who had hemoglobin A1c (HbA1c) control >9.0%.

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

Process Milestones:
- DY2: P-1; P-5
- DY3: P-2; P-4

Outcome Improvement Target(s) for each year:
- DY4:
  - IT- 1.10 Diabetes care: HbA1c poor control (>9.0%)
    - Decrease the percentage of patients in Medical Home with poorly controlled diabetes by 0.5% below baseline
- DY5
  - IT- 1.10 Diabetes care: HbA1c poor control (>9.0%)
    - Decrease the percentage of patients in Medical Home with poorly controlled diabetes by 1.0% below baseline

Rationale:
P-1 was chosen to ensure that all necessary stakeholders are consulted to develop strategies and processes necessary to reach patient satisfaction goals. P-5 will also be approached in DY2. We plan to share finding and lessons from project planning with internal and external stakeholders. In DY3, P-2 will produce a baseline HbA1c poor control (>9.0%) at the new West and Northwest 1 area health centers based on available data. In DY3, we will also conduct PDCA cycles for P-4 to ensure that strategies and processes for identified interventions are effective.

IT-1.10 will be measured beginning in DY4 to allow for time and resources needed to purchase lease space, hire staff, and operate the West and Northwest 1 area health centers for patient care and successful data calculation. Improvement targets were chosen with the expectation to decrease the percentage of patients with poorly controlled diabetes gradually to coincide with improvements in operations at the clinic.

Outcome Measure Valuation: This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic’s capacity to provide a medical home for primary care...
services, including laboratory point-of-care testing, some imaging, other ancillary services and prescription medications along with timely referrals for specialty care and other needed services within the Harris Health System network. The clinic can ultimately care for the comprehensive primary care needs of over five thousand patients annually, including the coordination of chronic disease education and management for patients needing those services. There are many ways to decrease HbA1c. Patient intervention may include medication management, behavioral modification, and individual and group education.

In addition, the availability of timely primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.
<table>
<thead>
<tr>
<th>133355104.3.4</th>
<th>3.IT-1.10</th>
<th>Percent improvement over baseline of diabetes care: HbA1c poor control (&gt;9.0%)</th>
</tr>
</thead>
</table>

**Harris Health System**

| 133355104.1.4 | 133355104 |

**Related Category 1 or 2 Projects:**

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1** [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

Data Source: EHR; Business Intelligence

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $413,673

**Process Milestone 2** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders

Data Source: EHR; Business Intelligence; reports

**Process Milestone 2 Estimated Incentive Payment:** $413,672

**Outcome Improvement Target 1** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%)

Improvement Target: Decrease percentage of patients in Medical Home with poorly controlled diabetes by 0.5% below baseline

Data Source: EHR

**Outcome Improvement Target 1 Estimated Incentive Payment:** $1,538,862

**Outcome Improvement Target 2** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%)

Improvement Target: Decrease percentage of patients in Medical Home with poorly controlled diabetes by 1.0% below baseline

Data Source: EHR

**Outcome Improvement Target 2 Estimated Incentive Payment:** $3,679,887

**Year 2 Estimated Outcome Amount:** $827,345

**Year 3 Estimated Outcome Amount:** $959,001

**Year 4 Estimated Outcome Amount:** $1,538,862

**Year 5 Estimated Outcome Amount:** $3,679,887

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $7,005,095
**Title of Outcome Measure (Improvement Target):** IT- 1.10 Diabetes care: HbA1c poor control (>9.0%)

**Unique RHP outcome identification number(s):** 133355104.3.5

**Performing Provider Name/TPI:** Harris Health System / 133355104

**Outcome Measure Description:**

As Performing Provider, Harris Health System chose IT1.10 to measure improvement in the percentage of patients 18-75 years of age with poorly controlled diabetes. Poorly controlled will be defined as patients with diabetes (type 1 or 2) who had hemoglobin A1c (HbA1c) control >9.0%.

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

**Process Milestones:**

- DY2: P-1; P-5
- DY3: P-2; P-4

**Outcome Improvement Target(s) for each year:**

- DY4:
  - IT- 1.10 Diabetes care: HbA1c poor control (>9.0%)
    - Decrease the percentage of patients in Medical Home with poorly controlled diabetes by 0.5% below baseline

- DY5:
  - IT- 1.10 Diabetes care: HbA1c poor control (>9.0%)
    - Decrease the percentage of patients in Medical Home with poorly controlled diabetes by 1.0% below baseline

**Rationale:**

P-1 was chosen to ensure that all necessary stakeholders are consulted to develop strategies and processes necessary to reach patient satisfaction goals. P-5 will also be approached in DY2. We plan to share finding and lessons from project planning with internal and external stakeholders. In DY3, P-2 will produce a baseline HbA1c poor control (>9.0%) at the new Northwest 2 area health center based on available data. In DY3, we will also conduct PDCA cycles for P-4 to ensure that strategies and processes for identified interventions are effective.

IT-1.10 will be measured beginning in DY4 to allow for time and resources needed to purchase lease space, hire staff, and operate the Northwest 2 area health centers for patient care and successful data calculation. Improvement targets were chosen with the expectation to decrease the percentage of patients with poorly controlled diabetes gradually to coincide with improvements in operations at the clinic.

**Outcome Measure Valuation:** This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic’s capacity to provide a medical home for primary care.
services, including laboratory point-of-care testing, some imaging, other ancillary services and prescription medications along with timely referrals for specialty care and other needed services within the Harris Health System network. Each clinic can ultimately care for the comprehensive primary care needs of over three thousand patients annually, including the coordination of chronic disease education and management for patients needing those services. There are many ways to decrease HbA1c. Patient intervention may include medication management, behavioral modification, and individual and group education.

In addition, the availability of timely primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.
### Percent improvement over baseline of diabetes care: HbA1c poor control (>9.0%)

**Harris Health System**

**Related Category 1 or 2 Projects:**

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
</table>

**Process Milestone 1 [P-1]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- Data Source: EHR; Business Intelligence

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $492,388

**Process Milestone 2 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders

- Data Source: EHR; Business Intelligence; reports

**Process Milestone 2 Estimated Incentive Payment:** $492,389

**Process Milestone 3 [P-2]:** Establish baseline for percentage of patients with poorly controlled HbA1c (>9.0%) at Northwest 2 area health center

- Data Source: EHR; Business Intelligence

**Process Milestone 3 Estimated Incentive Payment:** $570,743

**Process Milestone 4 [P-4]:** Conduct Plan Do Check Act (PDCA) cycles to improve intervention activities

- Data Source: Report documentation

**Process Milestone 4 Estimated Incentive Payment (maximum amount):** $570,742

**Outcome Improvement Target 1 [IT-1.10]:** Diabetes care: HbA1c poor control (>9.0%)

- Improvement Target: Decrease percentage of patients in Medical Home with poorly controlled diabetes by 0.5% below baseline

- Data Source: EHR

**Outcome Improvement Target 1 Estimated Incentive Payment:** $1,831,686

**Outcome Improvement Target 2 [IT-1.10]:** Diabetes care: HbA1c poor control (>9.0%)

- Improvement Target: Decrease percentage of patients in Medical Home with poorly controlled diabetes by 1.0% below baseline

- Data Source: EHR

**Outcome Improvement Target 2 Estimated Incentive Payment:** $4,380,119

<table>
<thead>
<tr>
<th>Year 5</th>
<th>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $984,777</th>
</tr>
</thead>
<tbody>
<tr>
<td>(10/1/2015 – 9/30/2016)</td>
<td>Year 3 Estimated Outcome Amount: $1,141,485 Year 4 Estimated Outcome Amount: $1,831,686 Year 5 Estimated Outcome Amount: $4,380,119</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $8,338,067
**Title of Outcome Measure (Improvement Target):** IT 6.2- Other: Percent improvement over baseline of Patient Satisfaction scores

**Unique RHP outcome identification number(s):** 133355104.3.6

**Performing Provider Name/TPI:** Harris Health System / 133355104

**Outcome Measure Description:**

IT 6.2 will measure improvement in the overall mean score for patient satisfaction over time using the standard same day access clinic survey supplied by Press Ganey and approved by HHSC.

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health System health centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care.

Same day access clinic operations will differ from current health centers, resulting in a need for a customized survey. The baseline patient satisfaction score at Southwest, Medical Center, and Northeast same day access clinics will be established in DY3 after a new, custom survey is developed and implemented through Press Ganey for same day access clinic usage.

**Process Milestones:**
- DY2: P-1; P-5
- DY3: P-2; P-4

**Outcome Improvement Target(s) for each year:**

- **DY4:**
  - IT 6.2- 0.5% improvement over baseline of patient satisfaction for overall mean survey score

- **DY5:**
  - IT 6.2- 1% improvement over baseline of patient satisfaction for overall mean survey score

**Rationale:**

P-1 was chosen to ensure that all necessary stakeholders are consulted to develop strategies and processes necessary to reach patient satisfaction goals. Moreover, a new, customized patient satisfaction survey will be developed for same day access clinics in partnership with Press Ganey. P-5 will also be approached in DY2. We plan to share finding and lessons from project planning with internal and external stakeholders. In DY3, P-2 will produce a baseline at the new same day access clinic based on available performance. In DY3, we will also conduct PDSA cycles for P-4 to ensure that strategies and processes for identified interventions are effective.
IT-6.2 will be measured beginning in DY4 to allow for time and resources needed to purchase lease space, hire staff, and operate the same day access clinic for patient care and successful survey calculation. Improvement targets were chosen with the expectation to reach patient satisfaction goals gradually to coincide with improvements in operations at the clinic. Based on Harris Health System’s historic Press Ganey patient satisfaction scores and the volume of patients served, we believe the percent improvement goals suggested are both challenging and meaningful.

**Outcome Measure Valuation:**

This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinics’ capacity to provide primary care services, including laboratory point-of-care testing, along with timely referrals for specialty care, imaging and other needed services within the Harris Health System network. Each of the three clinics can ultimately care for the episodic primary care needs of over six thousand patients annually, and refer new patients with chronic disease management needs to one of the NCQA certified medical home clinics that are operated by Harris Health. In addition, the availability of same day primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

Currently, some patients do not rate Harris Health positively due to the fact that waitlists to see providers are at times sixty plus days because of the high demand and limited providers. Because of the current back-log of patients, Harris Health System assures that by building more same day access clinics, we will meet the basic needs of thousands of more patients in a timely manner, giving Harris Health the ability to survey potentially 31,000 additional patients between DY3 and DY5, increasing the patient satisfaction score. From 2011 to 2012, Harris Health System’s existing Ambulatory Care Health Centers patient satisfaction score improved 2% across all health centers, leading us to believe that the goals we have established will be both challenging and meaningful upon establishing a baseline. For this project, Harris Health will implement a new survey tool for a different environment in which care will be provided; therefore, we wanted to keep the goals achievable as this will be a new endeavor for our system in terms of same day clinics and patient satisfaction.
### Harris Health System

#### Related Category 1 or 2 Projects:

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1 [P-1]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
Data Source: EHR; Business Intelligence

**Process Milestone 2 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders  
Data Source: EHR; Business Intelligence; reports

| Process Milestone 1 Estimated Incentive Payment (maximum amount): | $833,746 |
| Process Milestone 2 Estimated Incentive Payment: | $833,745 |

**Process Milestone 3 [P-2]:** Establish baseline patient satisfaction score at Southwest, Medical Center, and Northeast same day access clinics  
Data Source: Press Ganey

**Process Milestone 4 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve intervention activities  
Data Source: Report documentation

| Process Milestone 3 Estimated Incentive Payment: | $966,420 |
| Process Milestone 4 Estimated Incentive Payment: | $966,420 |

**Outcome Improvement Target 1 [IT-6.2]:** Percent improvement over baseline of patient satisfaction  
Improvement Target: Increase score by 0.5% above baseline  
Data Source: Press Ganey

| Outcome Improvement Target 1 Estimated Incentive Payment: | $3,101,534 |

**Outcome Improvement Target 2 [IT-6.2]:** Percent improvement over baseline of patient satisfaction  
Improvement Target: Increase score by 1% above baseline  
Data Source: Press Ganey

| Outcome Improvement Target 2 Estimated Incentive Payment: | $7,416,712 |

#### Outcome Improvement Target 1

| Year 2 Estimated Outcome Amount: | $1,667,491 |
| Year 3 Estimated Outcome Amount: | $1,932,840 |
| Year 4 Estimated Outcome Amount: | $3,101,534 |
| Year 5 Estimated Outcome Amount: | $7,416,712 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $14,118,577
Title of Outcome Measure (Improvement Target): IT-1.1 Third next available appointment

Performing Provider/TPI: Harris Health System/133355104
Unique RHP outcome identification number(s): 133355104.3.7
Outcome Measure Description:

OD-1 Primary Care and Chronic Disease Management
IT-1.1 Third next available appointment

Process Milestones:

- DY2:
  - P-2 Establish Baseline
  - P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

Outcome Improvement Targets for each year:

- DY3: decrease wait time from specialty referral to specialty clinic visit 5% from baseline
- DY4: decrease wait time from specialty referral to specialty clinic visit 10% from baseline
- DY5: decrease wait time from specialty referral to specialty clinic visit 15% from baseline

Rationale:

This particular improvement target, IT-1.1 (Third next available appointment) was chosen because a goal of this project is to produce more efficiencies in primary care visits that lead to appropriate specialty clinic referrals. With this goal in mind, a primary goal of the project is to decrease the backlog for diabetes and rheumatology clinics, which will ultimately decrease the wait time for next available appointment. Process milestone P-1 was chosen for DY2 because of the nature of this project. In order to see improvement in outcomes for this project, it is essential to plan and engage physician and other clinical stakeholders. During this year, a baseline will also be established (P-2) to measure improvement in later years. Based on the outcome of baseline, we plan to decrease the wait time 5% in DY3, 10% in DY4, and 15% in DY5.

Outcome Measure Valuation:

This project will focus primarily on diabetes mellitus (DM)/pre-diabetes and rheumatologic conditions, making it possible for providers to efficiently order the most appropriate best practices algorithm driven laboratory workups for particular patients. The value of the project is based on cost savings and efficiencies through (1) increasing the capacity of clinics and consulting services by reducing the number of patient visits required to solve diagnostic problems, (2) reducing the need for emergency room visits and hospitalizations that result from delayed or inaccurate diagnoses in the clinics, (3) increasing the throughput and productivity of the specialists consulting services by eliminating unnecessary consults, and (4) improving quality of care by decreasing the waiting time and eliminating unnecessary repeated visits due to incomplete pre-consult testing; thus enhancing patients’ satisfaction. In addition, these improvements will facilitate providing quality care for expected significant influx of patients due to implementation of Accountable Care Act (ACA) and the 1115 Waiver without a major increase in the number of providers and capital investment.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133355104.1.7</th>
<th>133355104</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td></td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Data Source: Referral Center reports</td>
<td>Outcome Improvement Target 1 [IT-1.1]: Third next available appointment Improvement Target: decrease wait time from specialty referral to specialty clinic visit for relevant specialty 5% from baseline Data Source: Referral Center Reports</td>
<td>Outcome Improvement Target 1 [IT-1.1]: Third next available appointment Improvement Target: decrease wait time from specialty referral to specialty clinic visit for relevant specialty 10% from baseline Data Source: Referral Center Reports</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $282,187</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $452,812</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $1,082,812</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $243,448</td>
<td>Year 3 Estimated Outcome Amount: $282,187</td>
<td>Year 4 Estimated Outcome Amount: $452,812</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $2,061,259*
**Title of Outcome Measure (Improvement Target):** IT-1.14 Diabetes care: Microalbumin/Nephropathy- NQF 0062 (non-standalone)

**Performing Provider/TPI:** Harris Health System/133355104  
**Unique RHP outcome identification number(s):** 133355104.3.8_(133355104.1.7)

**Outcome Measure Description:**
OD-1 Primary Care and Chronic Disease Management  
IT-1.14 Diabetes care: Microalbumin/Nephropathy- NQF 0062 (non-standalone)

**Process Milestones:**
- DY2: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
- DY3: P-2 Establish Baseline

**Outcome Improvement Targets for each year:**
- DY4: TBD based on established baseline in DY3  
- DY5: TBD based on established baseline in DY4

**Rationale:**
This particular improvement target, IT-1.14 (Diabetes care: Microalbumin/Nephropathy- NQF 0062) was chosen because a goal of this project is to produce more efficiencies in primary care visits that lead to appropriate specialty clinic referrals. There will be a focused algorithm on the diabetic population through this project. This is a large need in Harris County and the region. In creation of this algorithm, we plan to improve the percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy. This is an important measure in improving the population health of our diabetic population served. The improvement targets for this outcome measure will be determined based on the baseline that will be established in DY2. In order to see improvement in outcomes for this project, it is essential to plan and engage physician and other clinical stakeholders.

**Outcome Measure Valuation:**
This project will focus primarily on diabetes mellitus (DM)/pre-diabetes and rheumatologic conditions, making it possible for providers to efficiently order the most appropriate best practices algorithm driven laboratory workups for particular patients. The value of the project is based on cost savings and efficiencies through (1) increasing the capacity of clinics and consulting services by reducing the number of patient visits required to solve diagnostic problems, (2) reducing the need for emergency room visits and hospitalizations that result from delayed or inaccurate diagnoses in the clinics, (3) increasing the throughput and productivity of the specialists consulting services by eliminating unnecessary consults, and (4) improving quality of care by decreasing the waiting time and eliminating unnecessary repeated visits due to incomplete pre-consult testing; thus enhancing patients’ satisfaction. In addition, these improvements will facilitate providing quality care for expected significant influx of patients due to implementation of Accountable Care Act (ACA) and the 1115 Waiver without a major increase in the number of providers and capital investment.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Process Milestone 1 [P-2]: Establish Baseline rates</th>
<th>Outcome Improvement Target 1 [IT-1.14]: Diabetes care: Microalbumin/Nephropathy- NQF 0062</th>
<th>Outcome Improvement Target 1 [IT-1.14]: Diabetes care: Microalbumin/Nephropathy- NQF 0062</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Project Plans</td>
<td>Data Source: EHR</td>
<td>Improvement Target: TBD</td>
<td>Improvement Target: TBD</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $243,448</td>
<td>Process Milestone 2 Estimated Incentive Payment: $282,188</td>
<td>Data Source: EHR</td>
<td>Data Source: EHR</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $243,448</td>
<td>Year 3 Estimated Outcome Amount: $282,187</td>
<td>Year 4 Estimated Outcome Amount: $452,812</td>
<td>Year 5 Estimated Outcome Amount: $1,082,812</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $2,061,259*
**Title of Outcome Measure (Improvement Target):** IT-1.10 Diabetes care: HbA1c poor control (>9.0%)233- NQF 0059 (Standalone measure)

**Performing Provider/TPI:** Harris Health System/133355104  
**Unique RHP outcome identification number(s):** 133355104.3.9

**Outcome Measure Description:**

OD-1 Primary Care and Chronic Disease Management  
IT-1.10 Diabetes care: HbA1c poor control (>9.0%)233- NQF 0059 (Standalone measure)

a. Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%

b. Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

**Process Milestones:**

- DY2: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3: P-2 Establish Baseline

**Outcome Improvement Targets for each year:**

- DY4: 2% decrease from baseline
- DY5: 3% decrease from baseline

**Rationale:**

This particular improvement target IT-1.10 (Decrease in the percentage of patients with HbA1c > 9% from baseline) was selected as it could serve as an integral measure of diabetes patients care and of the success of efforts in DEEP and CEEP programs implementation as it is proposed in this project. This will reflect the concerted efforts of PCPs, endocrinologists and clinical pathologists executing the evidence-based best practice algorithmic approaches. Process milestone P-1 was chosen for DY2 because of the nature of this project. In order to see improvement in outcomes for this project, it is essential to plan and engage physician and other clinical stakeholders. During DY3, a baseline will be established (P-2) to measure improvement in later years. Based on the outcome of baseline, we plan to decrease the percentage of patients with HbA1c >9% by 2% in DY4 and by 3% in DY5. We plan these relatively modest percentages of improvement considering the high total volumes of diabetic patients within the Harris Health system and currently limited resources and workforce to address the problem.

**Outcome Measure Valuation:**

This project will focus on diabetes mellitus (DM) and pre-diabetes patients. Diabetes is one of the most costly and highly prevalent chronic diseases in the United States, for this matter in Texas and Harris County. Approximately 20.8 million Americans have diabetes and about half of these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and...
addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars. That is why introduction of the DEEP and CEEP programs proposed in the current project is of paramount importance and selection of appropriate measure of the achieved results is critical. Additionally, the possibility for providers to efficiently order the most appropriate best practices algorithm driven laboratory workups for DM patients is an extra value of the project. It is based on cost savings and efficiencies through (1) increasing the capacity of clinics and consulting services by reducing the number of patient visits required to solve diagnostic problems, (2) reducing the need for emergency room visits and hospitalizations that result from delayed or inaccurate diagnoses in the clinics. (3) increasing the throughput and productivity of the specialists consulting services by eliminating unnecessary consults, and (4) improving quality of care by decreasing the waiting time and eliminating unnecessary repeated visits due to incomplete pre-consult testing; thus enhancing patients’ satisfaction. These improvements will also facilitate providing quality care for expected significant influx of patients due to implementation of ACA and the 1115 Waiver without a major increase in the number of providers and capital investment.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133355104.1.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
</tr>
</tbody>
</table>

### Year 2 (10/1/2012 – 9/30/2013)

**Process Milestone 1 [P-1]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
Data Source: Project Plans  
Process Milestone 1 Estimated Incentive Payment: $243,448

**Process Milestone 1 [P-2]:** Establish Baseline rates  
Data Source: EHR, Registry, Claims, Administrative clinical data  
Process Milestone 2 Estimated Incentive Payment: $282,188

**Outcome Improvement Target 1 [IT-1.10]:** Diabetes care: HbA1c poor control (>9.0%) - NQF 0059  
Improvement Target: 2% below baseline  
Data Source: EHR, Registry, Claims, Administrative clinical data  
Outcome Improvement Target 2 Estimated Incentive Payment: $452,812

### Year 3 (10/1/2013 – 9/30/2014)

**Outcome Improvement Target 1 [IT-1.10]:** Diabetes care: HbA1c poor control (>9.0%) - NQF 0059  
Improvement Target: 2% below baseline  
Data Source: EHR, Registry, Claims, Administrative clinical data  
Outcome Improvement Target 2 Estimated Incentive Payment: $452,812

### Year 4 (10/1/2014 – 9/30/2015)

**Outcome Improvement Target 1 [IT-1.10]:** Diabetes care: HbA1c poor control (>9.0%) - NQF 0059  
Improvement Target: 3% below baseline  
Data Source: EHR, Registry, Claims, Administrative clinical data  
Outcome Improvement Target 3 Estimated Incentive Payment: $1,082,812

### Year 5 (10/1/2015 – 9/30/2016)

**Outcome Improvement Target 1 [IT-1.10]:** Diabetes care: HbA1c poor control (>9.0%) - NQF 0059  
Improvement Target: 3% below baseline  
Data Source: EHR, Registry, Claims, Administrative clinical data  
Outcome Improvement Target 3 Estimated Incentive Payment: $1,082,812

**Year 2 Estimated Outcome Amount:** $243,448  
**Year 3 Estimated Outcome Amount:** $282,187  
**Year 4 Estimated Outcome Amount:** $452,812  
**Year 5 Estimated Outcome Amount:** $1,082,812

**Total Estimated Incentive Payments for 4-Year Period:** ($2,061,259)

*Region 3*
Title of Outcome Measure (Improvement Target): IT- 6.2 Percent improvement over baseline of patient satisfaction

Unique RHP Outcome ID: 133355104.3.10
Performing Provider Name/TPI: Harris Health System / 133355104

Outcome Measure Description:
IT-6.2 will measure improvement in overall satisfaction scores over time at FQHCs of the Access dimension, using Press Ganey’s Medical Practice Survey.

The baseline will be established using patient satisfaction survey data from each FQHC, with each FQHC’s score to be tracked and trended separately. The baseline patient satisfaction score at the FQHC’s will be established in DY3. At Harris Health System, timeliness of care scores is negatively affected by access and capacity. From March 2012-September 2012, the Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. As a result, the mean patient satisfaction score for Moving Through Your Visit for the last 12 months (9/2011-9/2012) was 70.2 for all primary care health centers at Harris Health System, as reported through the survey administered by Press Ganey. Expanded capacity and optimized referrals to FQHCs can improve patient satisfaction regarding timely care.

Process Milestones:
• DY2: P-1; P-5
• DY3: P-2; P-4

Outcome Improvement Target(s) for each year:
• DY4:
  • [IT-6.2]: Percent improvement over baseline of patient satisfaction scores of the Access dimension
    Improvement Target: Increase satisfaction scores by 0.5% above baseline (for FQHCs with established referral process in DY3)

• DY5
• [IT-6.2]: Percent improvement over baseline of patient satisfaction scores of the Access dimension
  Improvement Target: Increase satisfaction scores by 0.5% above baseline for FQHCs with an established referral process in DY4, and by 1% above baseline for FQHCs with an established referral process in DY3

Rationale:
P-1 was chosen to ensure that all necessary stakeholders are consulted to develop strategies and processes necessary to reach patient satisfaction goals and collect data from each FQHC. P-5 will also be approached in DY2. We plan to share findings and lessons from project planning with internal and external stakeholders. In DY3, P-2 will produce a baseline score for timeliness of care at FQHCs. In DY3, we will also conduct PDSA cycles for P-4 to ensure that strategies and processes for identified interventions are effective. We plan to share findings and lessons from project planning with internal and external stakeholders.

IT-6.2 will be measured beginning in DY3 to allow for time and resources needed for the FQHC to hire providers and staff, begin seeing patients, and successfully collect significant
survey data. Improvement targets were chosen with the expectation to reach patient satisfaction goals gradually to coincide with improvements in operations at the FQHCs.

**Outcome Measure Valuation:** This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved/uninsured population in Harris County. It will expand capacity for primary care medical homes and connect patients to care in a timely fashion that might not otherwise be possible. A referral system will be developed for patients who seek an appointment at the Harris Health System for whom the demand cannot be met in a timely manner, as well as for patients who seek care for primary care treatable conditions in the Harris Health Emergency Centers. The value of the project is based on the incremental capacity to provide primary care services at the community FQHCs, along with timely referrals for specialty care and other needed services within the Harris Health System network. This expansion can ultimately care for the primary care needs of over eight thousand patients annually. In addition, the availability of incremental primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.
### Outcome Improvement Target 2

**[IT- 6.2]: Percent improvement over baseline of patient satisfaction (Access dimension)**

**Improvement Target:** Increase satisfaction scores by 0.5% above baseline for FQHCs with an established referral process in DY3.

**Data Source:** Press Ganey Medical Practice Surveys

**Estimated Incentive Payment:** $535,387.50

---

### Outcome Improvement Target 3

**[IT- 6.2]: Percent improvement over baseline of patient satisfaction (Access dimension)**

**Improvement Target:** Increase satisfaction scores by 0.5% above baseline for FQHCs with an established referral process in DY4 and by 1% above baseline for FQHCs with an established referral process in DY3.

**Data Source:** Press Ganey Medical Practice Surveys

**Estimated Incentive Payment:** $2,560,550

---

### Year 2 Estimated Outcome Amount

**$575,686**

### Year 3 Estimated Outcome Amount

**$667,295**

### Year 4 Estimated Outcome Amount

**$1,070,775**

### Year 5 Estimated Outcome Amount

**$2,560,550**
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133355104.1.8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be established in DY3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $4,874,306*
Title of outcome measure (improvement target): IT-6.2-Other: Percent improvement over baseline of patient satisfaction scores: patients are getting timely care, appointments, and information

Performing Provider/TPI: Harris Health System/133355104

Unique RHP outcome identification number: 133355104.3.11 / Pass 1

Outcome Measure Description:
Process Milestones
• DY2: P-1
• DY3: P-2

Outcome Improvement Targets: IT-6.1(1)
• DY4 Target: .5% improvement over baseline
• DY5 Target: 1% improvement over baseline

Will be determined based on patient satisfaction scores for timely care, appointments, and information from Press-Ganey survey results. These surveys are currently being gathered by Press-Ganey and will incorporate the new services upon implementation of pediatric and adolescent behavioral health services.

Rationale:
The goal of this project is to increase psychiatry and behavioral therapy staffing at existing pediatric locations within Harris Health System. Expanding pediatric and adolescent behavioral health services has the potential to help decrease the future need for inpatient behavioral health beds by addressing issues at earlier stages in life. Untreated behavioral health needs may lead to school failure, behavioral conflicts, and substance abuse; the longer the issues are left untreated, the more difficult and costly it is to provide effective treatment. The increase in provider staffing throughout the existing pediatric services network can ultimately meet the behavioral care needs of an additional eight thousand patients annually.

We have selected process milestone, P-1, for DY2 in order to begin expansion of pediatric and adolescent behavioral health services at Harris Health System. This process milestone will allow us to plan for outcome reporting of patient satisfaction per our chosen outcome measure. We have selected process milestone P-2 for DY2 to establish the baseline for our outcome improvement targets to be measured in DY4 and DY5. We will begin reporting on improvement target IT-6.1(1) in DY3. By DY5 we want to increase patient satisfaction by 1% across all targeted sites. We selected a low increase because many existing sites have higher than average patient satisfaction scores within the Harris Health System. Pediatric sites start in the highest percentile ranking benchmarked to other national facilities.

Outcome Measure Valuation:
The goal of this project is to increase psychiatry and behavioral therapy staffing at existing pediatric locations within Harris Health System. Expanding pediatric and adolescent behavioral health services has the potential to help decrease the future need for inpatient behavioral health beds by addressing issues at earlier stages in life. Untreated behavioral health needs may lead to school failure, behavioral conflicts, and substance abuse; the longer the issues are left untreated, the more difficult and costly it is
to provide effective treatment. The increase in provider staffing throughout the existing pediatric services network can ultimately meet the behavioral care needs of an additional eight thousand patients annually. With this project, we project an additional 37,319 cumulative visits by DY5. While increasing access, it is important that we not only maintain, but continue to improve our patient satisfaction scores. This is especially important when increasing to such a large number of visits through the life of this project and after.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133355104.1.9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]:</td>
<td><strong>Process Milestone 2</strong> [P-2]:</td>
<td><strong>Outcome Improvement Target 2</strong></td>
<td><strong>Outcome Improvement Target 3</strong></td>
</tr>
<tr>
<td>Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Establish baseline rates</td>
<td>[IT-6.2]: Percent improvement over baseline of patient satisfaction scores: patients are getting timely care, appointments, and information</td>
<td>[IT-6.2]: Percent improvement over baseline of patient satisfaction scores: patients are getting timely care, appointments, and information</td>
</tr>
<tr>
<td>Data Source: EHR reports</td>
<td>Data Source: Press-Ganey Survey Reports</td>
<td>Improvement Target: .5%</td>
<td>Improvement Target: 1%</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $530,747</td>
<td>Process Milestone 1 Estimated Incentive Payment: $615,205</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $987,189</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $2,360,670</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: $530,747 | Year 3 Estimated Outcome Amount: $615,205 | Year 4 Estimated Outcome Amount: $987,189 | Year 5 Estimated Outcome Amount: $2,360,670 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $4,493,811
**Title of Outcome Measure (Improvement Target):** IT-1.19 Antidepressant Medication Management

**Unique RHP outcome identification number(s):** 133355104.3.12

**Performing Provider Name/TPI:** Harris Health System / 133355104

**Outcome Measure Description:**
IT-1.19 will be defined as Rate A) and Rate B):

A. **Effective Acute Phase Treatment:** At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

B. **Effective Continuation Phase Treatment:** At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

The numerator for Rate A) will consist of Harris Health System discharged patients 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year and with at least 84 days of continuous treatment with antidepressant medication during the 114-day period following the IPDS.

The numerator for Rate B) will consist of Harris Health System discharged patients 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year and with at least 180 days of continuous treatment with antidepressant medication during the 231-day period following the IPDS.

**Denominator:** Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year.

**Process Milestones:**
- DY2: P-1
- DY3: P-2, P-4

**Outcome Improvement Target(s) for each year:**
- DY4: IT-1.19 Antidepressant Medication Management
  - Increase Rate A) and Rate B): TBD
DY5: IT-1.19 Antidepressant Medication Management

Rationale:

Measurements are for any patient with a primary diagnosis of mental health and prescription of an antidepressant medication. Data will be obtained via Harris Health EHR, decision support and claims. The % of patients meeting the criteria will be sequentially increased across DY 4, 5. Baseline established in DY 3. Change text for DY4 and 5 to reflect the actual measures.

The outcome measures of adherence are important specific to the patient engagement in their disease process and the ability to effect mental health distress and behaviors exhibited as a result of major depression. Adherence to medications is a common issue in the United States and accounts for as much as 50% in chronic disease populations\(^1\) and there is approximately only 30% adherence for patients diagnosed with major depression.\(^2\)

Lack of adherence to medication regimes can be indicative of financial limitations that decrease access to necessary medications. Such barriers can be addressed by the mental health professional and the social worker in the community health center. Adherence to medications can be impacted by cultural beliefs and family dynamics that will be identified as part of this initiative and addressed in mental health sessions. Non-adherence can be related to medication side effects, guilt, and insufficient time allowed for the medication to be effective\(^2\); all of which can be explained by increasing access to mental health providers and professionals.

Process improvement milestones of P-1 and P-2 were selected as a means to permit time for engagement of stakeholders to discuss, collaborate, and implement a comprehensive approach to promote medication adherence for patients diagnosed with major depression. The provision of planning to secure supplies, and stakeholder involvement in the types of services to be offered is essential, to promote the necessary collaboration required as part of an enhanced psychiatric and mental health access to services. Project planning will also include the necessary education of providers, existing staff, recruited staff, and also development of patient materials in the healthcare language of patient choice, and at the 5th grade literacy level, specifically for Harris Health patient population. Additionally, the ability to secure key performance indicators required as part of the project and the reporting required to evaluate the outcomes delineated in DY4 and DY5 is paramount to tracking and monitoring quality, access, and cost of care. Improvement targets were placed in DY4 and DY5 in order to collect data and improve upon the established baseline determined in DY3.

Outcome Measure Valuation:

The goal of this project is to increase psychiatry and behavioral therapy staffing at current medical home primary care clinics, in existing underutilized space, to increase access to care for psychiatric mental health. All of the targeted health centers offer behavioral services; however

---


the hours and appointment availability are limited. Service hours and appointment capacity will be expanded within each of the clinics. Enhanced access to mental health services and the ability to track and monitor medication adherence will promote a decrease in acute care and emergency center visit utilization, as well as potentially decrease the need for additional inpatient psychiatric beds, thereby lowering the overall cost of care. The increase in provider staffing throughout the existing primary care services network can ultimately meet the behavioral care needs of an additional seven thousand patients annually.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Process Milestone 1 [P-1]**: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans | **Process Milestone 2 [P-2]**: Establish baseline rates for Rate A) and Rate B)  
Data Source: EHR | **Outcome Improvement Target 1**  
**IT:1.19**: Antidepressant Medication Management  
Improvement Target: TBD  
Data Source: EHR | **Outcome Improvement Target 2**  
**IT:1.19**: Antidepressant Medication Management  
Improvement Target: TBD  
Data Source: EHR |
| Process Milestone 1 Estimated Incentive Payment: $622,680 | Process Milestone 2 Estimated Incentive Payment (maximum amount): $360,884 | Outcome Improvement Target 1 Estimated Incentive Payment: $1,158,186 | Outcome Improvement Target 2 Estimated Incentive Payment: $2,769,575 |
| Year 2 Estimated Outcome Amount: $622,680 | Year 3 Estimated Outcome Amount: $721,768 | Year 4 Estimated Outcome Amount: $1,158,186 | Year 5 Estimated Outcome Amount: $2,769,575 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5)*: $5,272,209
**Outcome Measure (Improvement Target):** IT-3.2 Congestive Heart Failure 30 Day Readmission Rate

**Performing Provider/TPI:** Harris Health System/133355104

**Unique RHP Outcome ID:** 133355104.3.13 (133355104.1.11)

**Outcome Measure Description:**
IT-3.2 Congestive Heart Failure 30 Day Readmission Rate will measure the rate of readmissions, for any cause, within 30 days of discharge from the index HF admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

The implementation of a chronic disease registry will permit the timely identification of patients at risk for acute care utilization relative to chronic disease and the respective patient’s ability to appropriately self-manage their disease process. The disease registry will be utilized to identify patients with chronic disease to include the ambulatory sensitive conditions of COPD, Asthma, Diabetes, Heart Failure and Hypertension. The outcome measurement is specifically pertinent to self-management of the heart failure disease process to educate and manage patients to decrease readmissions for heart failure (IT-3.2); within 30 days of the index admission.

A disease registry stratifies the patients according to geographic location to promote the development of accessible programs to foster education, classes, telephonic outreach and case management services specific to the chronic disease diagnosed. The disease registry tracks utilization which will promote transparency of information sharing relative to appropriate and inappropriate utilization, and facilitates provider education respective to evidence based practice for the treatment of chronic disease. The disease registry additionally displays the gaps in service availability via the monitoring of patterns of utilization locations and the hours of service accessed. The proposed will impact (based on historical data) greater than 700 patients within a one year period. This estimate is conservative as such does not include new expansion, new programs for Heart Failure, or identification of new cases via the proposed registry.

**Process Milestones:**
- DY2: P-1; P-2
- DY3: P-4

**Outcome Improvement Target(s) for each year:**
- DY4:
  - IT-3.2 Congestive Heart Failure 30 Day Readmission Rate
    - Decrease the congestive heart failure 30 day readmission rate by 1% of baseline
- DY5:
  - IT-3.2 Congestive Heart Failure 30 Day Readmission Rate
    - Decrease the congestive heart failure 30 day readmission rate by 5% of baseline
**Rationale:**
Process improvement milestones of P-1 and P-2 were selected as a means to permit time for engagement of stakeholders to secure comprehensive registry system to provide the definitive functionality required. Additionally, the ability to secure key performance indicators required electronically as part of the initiative, and the capacity for reporting will require cohesive planning, implementation, and testing prior to go-live. Improvement targets were placed in DY3-5 in order to collect data and improve upon the established baseline determined in DY2. The baseline will dictate an appropriate improvement target goal.

**Outcome Measure Valuation:**
The purpose of the implementation of a disease registry is to provide the ability to identify patients at risk based on chronic disease states and associated utilization patterns that will facilitate the ability to identify gaps in service and deficits in patient understanding and self-management of their disease. Patients with chronic illness will have improved health, via education and case management, the cost per patient is decreased due to decreased acute care and emergency visit utilization, and the patient’s quality of life is improved. Harris Health internal data for the most recent year has 47,000 patients with one or more of the top 5 diagnoses of chronic disease – heart failure, hypertension, obesity, depression, and chronic respiratory. With a disease registry allowing us to establish clear incidence and prevalence data, the cost saving opportunity related to the potential improved management of these conditions is substantial.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133355104.1.11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be established in DY2.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

### Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- **Data Source:** Project planning documentation/report
- **Estimated Incentive Payment:** $567,697

### Process Milestone 2 [P-2]: Establish baseline rate for Congestive Heart Failure 30 Day Readmission
- **Data Source:** EHR
- **Estimated Incentive Payment:** $329,017

### Process Milestone 3 [P-4]: Conduct PDSA cycles to improve data collection and intervention activities
- **Data Source:** EHR, utilization reports
- **Estimated Incentive Payment:** $329,017

### Outcome Improvement Target 1
- **IT-3.2**: Congestive Heart Failure 30 Day Readmission Rate
- **Improvement Target:** 1% of baseline
- **Data Source:** EHR
- **Estimated Incentive Payment:** $1,055,916

### Outcome Improvement Target 2
- **IT-3.2**: Congestive Heart Failure 30 Day Readmission Rate
- **Improvement Target:** 5% of baseline
- **Data Source:** EHR
- **Estimated Incentive Payment:** $2,525,016

### Year 2 Estimated Outcome Amount: $567,697
### Year 3 Estimated Outcome Amount: $658,034
### Year 4 Estimated Outcome Amount: $1,055,916
### Year 5 Estimated Outcome Amount: $2,525,016

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $4,806,663
Title of Outcome Measure (Improvement Target): IT-4.6 Hospital-acquired Venous Thrombembolism (VTE)

Performing Provider/TPI: Harris Health System/133355104
Unique RHP outcome ID: 133355104.3.14

Outcome Measure Description:
IT- 4.6 will measure the number of cases of VTEs at Harris Health System. Reduction of VTE rates was chosen as an outcome measure as it requires process improvements from an interdisciplinary team of providers and innovators. Sustained improvements can be reached by redesigning our processes throughout Harris Health System’s inpatient settings.

Process Milestones:
- DY2: P-1
- DY3: P-2; P-4

Outcome Improvement Target(s) for each year:
- DY4:
  - IT-4.6 Hospital-acquired Venous Thrombembolism (VTE)
    - Decrease the number of cases of VTEs by 2% below baseline
- DY5:
  - IT-4.6 Hospital-acquired Venous Thrombembolism (VTE)
    - Decrease the number of cases of VTEs by 5% below baseline

Rationale:
Process milestones –P-1 through P-3 develops the infrastructure of quality improvement, clinical effectiveness, systems engineering and other expertise to build the foundation for all subsequent processes. A baseline rate (P-2) for hospital acquired Venous Thrombembolism (VTE) at Harris Health System will also be established in DY2 for performance purposes. Improvement targets were placed in DY4 and 5 based on implementation of practices with rapid testing cycles for sustainable change in multiple clinical units and hospitals.

Outcome Measure Valuation:
The goal of the center is to define high impact opportunities in patient safety, clinical effectiveness of evidence based best practices, population health, care coordination and unmet patient needs in Medicaid and uninsured patients. The center design team will partner with healthcare providers, patients and other stakeholders to develop innovation strategies and plans, and pilot the implementation. As noted earlier, centers of healthcare innovation at other prominent healthcare organizations are excellent references. The success of these programs demonstrates high reliability organizations in patient safety, clinical effectiveness, cost of care and integration of nontraditional community resources to improve health. These centers have reduced patient harm, improved mortality, reduced patient admissions, readmissions and emergency room visits, improved patient satisfaction and reduced disparities in healthcare delivery. One of the goals of the center is to reduce hospital acquired conditions. VTEs add an average cost of $63,000 per case and leads to increased morbidity and mortality. Through the expertise in the science of healthcare delivery, systems engineering, and human factors, the center will innovate to reduce variability in care delivery leading to improved outcomes. The VTE improvement program will be the initial project to build infrastructure and processes of the center. Unmet patient needs within the Medicaid and indigent population will then be targeted by the center. It will focus on high impact opportunities in patient safety, clinical effectiveness, population health and care coordination. The center will partner with providers and patients in the inpatient, outpatient, and community settings.
<table>
<thead>
<tr>
<th>Year</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]:</td>
<td>Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 3 [P-4]:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>Outcome Improvement Target 1 [IT-4.6]: Hospital-acquired Venous Thrombembolism rates Improvement Target: 2% Decrease from baseline in rate of VTEs at Harris Health System Data Source: EHR, Claims, IQR/NHSN data</td>
<td>Outcome Improvement Target 2 [IT-4.6]: Hospital-acquired Venous Thrombembolism rates Improvement Target: 5% Decrease from baseline in rate of VTEs at Harris Health System Data Source: EHR, Claims, IQR/NHSN data</td>
</tr>
<tr>
<td>Data Source: Planning documentation</td>
<td>Process Milestone 3 Estimated Incentive Payment: $1,219,515</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $1,956,897</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $4,679,536</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $526,047.50</td>
<td><strong>Process Milestone 2 [P-2]:</strong> Establish baseline rates at Harris Health System- Hospital-acquired Venous Thrombembolism (VTEs) Data Source: EHR</td>
<td><strong>Outcome Improvement Target 1 [IT-4.6]:</strong> Hospital-acquired Venous Thrombembolism rates Improvement Target: 2% Decrease from baseline in rate of VTEs at Harris Health System Data Source: EHR, Claims, IQR/NHSN data</td>
<td><strong>Outcome Improvement Target 2 [IT-4.6]:</strong> Hospital-acquired Venous Thrombembolism rates Improvement Target: 5% Decrease from baseline in rate of VTEs at Harris Health System Data Source: EHR, Claims, IQR/NHSN data</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $1,052,095</td>
<td>Year 3 Estimated Outcome Amount: $1,219,515</td>
<td>Year 4 Estimated Outcome Amount: $1,956,897</td>
<td>Year 5 Estimated Outcome Amount: $4,679,536</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYS 2-5): $8,908,043
**Title of Outcome Measure (Improvement Target):** IT-5.1- Improved cost savings: Demonstrate cost savings in care delivery

**Performing Provider/TPI:** Harris Health System/133355104

**Unique RHP outcome identification number:** 133355104.3.15

**Outcome Measure Description:**
OD-5 Cost of Care – IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery

Harris Health System’s central fill will decrease costs through efficiencies gained with central fill automation (robotics, conveyor system, sorting and packing technology) thus decreasing labor costs. Therefore, we will measure the decreasing average labor cost per prescription as the percentage of total prescriptions processed through automation increases.

a) We will implement cost accounting systems to measure intervention impacts by monitoring average labor cost per prescription.

b) We will establish a method to measure cost containment by using the total salaries and benefits (as the numerator) and total number of ambulatory prescriptions filled (as the denominator) as stated on the monthly operating statements.

c) We will use the current state from the month preceding implementation as our baseline for cost. We currently have no automation.

d) We will measure cost containment by comparing the project’s average labor cost per prescription and the percentage of prescriptions filled at the central fill site to the baseline at yearly intervals.

This cost savings is based on the current volume of 2.5M total prescriptions per year.

**Process Milestones:**
- **DY2:** P-2 Establish a baseline rate

**Improvement Milestones:**
- **DY3-DY5:** IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (stand-alone)

**Outcome Improvement Targets:**
- **DY3:** Cost savings: 7% decrease in average labor cost per prescription when processing 40% of the total Harris Health System ambulatory volume at the central fill facility by the end of the year.
- **DY4:** Cost savings: 19% decrease in average labor cost per prescription over established baseline by processing 50% of the total Harris Health System ambulatory volume at the central fill facility.
- **DY5:** Cost savings: 31% decrease in average labor cost per prescription over established baseline by processing 60% of the total Harris Health System ambulatory volume at the central fill facility.
**Rationale:**

Our process milestone P-2 is to establish a baseline cost based on current state before implementation of central fill.

Outcome Improvements will be analyzed by the Cost Benefit Analysis comparing the average labor cost per prescription at the goal percentage rates compared to baseline average labor cost per prescription.

Considering that there is no current automation at Harris Health System Department of Pharmacy for prescription processing, the baseline rate will be the average labor cost per prescription when 0% of prescriptions are filled at the central fill facility. The data source will be the monthly operating statement from the month prior to go-live.

In DY3 cost savings result from a 7% decrease the average labor cost per prescription using the total salaries and benefits/total number of Harris Health System prescriptions as found on the monthly operating statement compared to baseline. The cost savings are a result of automation efficiencies.

In DY4, cost savings result from a 19% decrease from baseline in the average labor cost per prescription using the total salaries and benefits/total number of Harris Health System prescriptions as found on the monthly operating statement compared to baseline. The cost savings are a result of automation efficiencies.

In DY5, cost savings result from a 31% decrease from baseline in the average labor cost per prescription using the total salaries and benefits/total number of Harris Health System prescriptions as found on the monthly operating statement compared to baseline. The cost savings are a result of automation efficiencies.

**Outcome Measure Valuation:** This project is a supporting pillar for one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in Harris County. The value of the project is based on cost avoidance, projecting savings associated with reducing the costs incurred in filling 2.5 million current patient prescriptions on an annual basis. Based on the increase in primary care volumes addressed in several other Harris Health System Waiver projects, further growth in volume to over 3.0 million prescriptions is projected. Despite this increase in prescription volume, processing costs are projected to decrease in total with the addition of the central fill function. The prompt availability of needed prescriptions for our underserved patients, particularly those with chronic disease that can be managed effectively with appropriate pharmaceuticals, will result in fewer emergency room visits for public and private hospitals located in the service area, and will also help to prevent future downstream inpatient admissions.
### Improved cost savings: Demonstrate cost savings in care delivery (stand alone)

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harris Health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% of total prescription volume filled by automation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 [P-2]</strong>: Establish a baseline for cost</td>
<td><strong>Outcome Improvement Target 1</strong> [IT-5.1]: Improved cost savings: Demonstrate cost savings in care delivery</td>
<td><strong>Outcome Improvement Target 2</strong> [IT-5.1]: Improved cost savings: Demonstrate cost savings in care delivery</td>
<td><strong>Outcome Improvement Target 3</strong> [IT-5.1]: Improved cost savings: Demonstrate cost savings in care delivery</td>
</tr>
<tr>
<td><strong>Metric 1 [P-2.1]</strong>: Average labor cost per prescription</td>
<td>Type of analysis: Cost Benefit Analysis using average labor cost per prescription calculated by total salaries and benefits divided by total # prescriptions Improvement Target: Decrease average labor cost per prescription 7% from established baseline (based on 2.5M annual prescription volume) Data Source: Operating statements from the month immediately preceding implementation of Central Fill project</td>
<td>Type of analysis: Cost Benefit Analysis using average labor cost per prescription calculated by total salaries and benefits divided by total # prescriptions Improvement Target: Decrease average labor cost per prescription 19% from baseline (based on 2.5M annual prescription volume) Data Source: Operating statements from the month immediately preceding implementation of Central Fill project</td>
<td>Type of analysis: Cost Benefit Analysis using average labor cost per prescription calculated by total salaries and benefits divided by total # prescriptions Improvement Target: Decrease average labor cost per prescription 31% from baseline (based on 2.5M annual prescription volume) Data Source: Operating statements from the month immediately preceding implementation of Central Fill project</td>
</tr>
<tr>
<td><strong>Goal</strong>: Provide documentation of the updated baseline average cost/Rx</td>
<td><strong>Data Source</strong>: Monthly operating statements – Total Salaries &amp; Benefits and Prescription Statistics</td>
<td><strong>Data Source</strong>: Monthly operating statements – Total Salaries &amp; Benefits and Prescription Statistics</td>
<td><strong>Data Source</strong>: Monthly operating statements – Total Salaries &amp; Benefits and Prescription Statistics</td>
</tr>
<tr>
<td><strong>Milestone 1 Estimated Incentive Payment (maximum amount)</strong>: $806,743</td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment</strong>: $935,120</td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment</strong>: $1,500,542</td>
<td><strong>Outcome Improvement Target 3 Estimated Incentive Payment</strong>: $3,588,253</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount</strong>: $806,743</td>
<td><strong>Year 3 Estimated Outcome Amount</strong>: $935,120</td>
<td><strong>Year 4 Estimated Outcome Amount</strong>: $1,500,542</td>
<td><strong>Year 5 Estimated Outcome Amount</strong>: $3,588,253</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $6,830,658
Title of Outcome Measure (Improvement Target): IT-9.4 Reduce ER Utilization for Frequent User Cohort

Performing Provider/TPI: Harris Health System/133355104

Unique RHP Outcome Identification Number: 133355104.3.16

Outcome Measure Description:
IT-9.4 will measure the reduction in ER utilization for the identified frequent user cohort.

This project will identify the highest utilizers of emergency room services in the Harris health System, and implement personalized navigation and management plans in order to decrease the annual rate of usage for these patients. The value of the project is based on cost savings associated with a substantial reduction in the utilization of emergency services, as well as helping to prevent future downstream inpatient admissions that frequently occur in this population. While the initial focus will begin with the top 100 patients, as the program expands we will drill further into the emergency room population and enroll more patients, as appropriate.

Process Milestones:
- DY2: P-1
- DY3: P-2

Outcome Improvement Targets:
- DY4: Reduce utilization rate by 10% compared to baseline
- DY5: Reduce utilization rate by 20% compared to baseline

Rationale:
Because this is a new service, process milestones P-1 and P-2 were selected in order to plan for the program and establish baseline metrics. Outcome IT-9.4 was selected to measure overall utilization of ER resources by the most frequent users. Decreases in ER resource utilization will reflect the success of the navigation program. The goals reflect that not all patients may engage fully in the navigation program. 1

In 2010, over 40% of Harris County ER visits by Harris County residents were primary care related, these include visits for conditions that are non-urgent, primary care treatable, and primary care preventable. The average cost to treat these patients in the ER versus a primary care setting was approximately $800 per visit for all age groups. Connecting patients who frequent the ER with consistent, coordinated primary and specialty care access will improve clinical outcomes, which will decrease the need to access emergent services.

**Outcome Measure Valuation:**
This project will identify the highest utilizers of emergency room services in the Harris health System, and implement personalized navigation and management plans in order to decrease the annual rate of usage for these patients. The value of the project is based on cost savings associated with a substantial reduction in the utilization of emergency services, as well as helping to prevent future downstream inpatient admissions that frequently occur in this population. While the initial focus will begin with the top 100 patients, as the program expands we will drill further into the emergency room population and enroll more patients, as appropriate.
<table>
<thead>
<tr>
<th>Related Category 2 Projects:</th>
<th>133355104.2.2</th>
</tr>
</thead>
</table>

| Starting Point/Baseline: | To be established in DY3. |

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1** [P-1]: Complete project plan
- Data Source: Project plan document.
- Process Milestone 1 Estimated Incentive Payment: $368,321

**Process Milestone 2** [P-2]: Establish baseline EC utilization rate for top 100 frequent ER users
- Data Source: EHR
- Process Milestone 2 Estimated Incentive Payment: $426,933

**Outcome Improvement Target 1** [IT-9.4]: Reduce ER utilization rate for frequent user cohort
- Improvement Target: Reduce utilization rate by 10% compared to baseline
- Data Source: EHR
- Estimated Incentive Payment: $685,078

**Outcome Improvement Target 2** [IT-9.4]: Reduce EC utilization rate for frequent user cohort
- Improvement Target: Reduce utilization rate by 20% compared to baseline
- Data Source: EHR
- Estimated Incentive Payment: $1,638,229

**Year 2 Estimated Outcome Amount:** $368,321

**Year 3 Estimated Outcome Amount:** $426,933

**Year 4 Estimated Outcome Amount:** $685,078

**Year 5 Estimated Outcome Amount:** $1,638,229

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $3,118,561
Title of Outcome Measure (Improvement Target): IT-9.4-Reduce Left Without Being Seen (LWBS) Rates for ESI Level 4 and 5

Performing Provider/TPI: Harris Health System/133355104
Unique RHP Outcome Identification Number: 133355104.3.17

Outcome Measure Description:
In an effort to improve the quality of care and patient satisfaction, it is a common goal of emergency centers to provide contact to a provider as quickly as possible. Patients who present with low acuity complaints (ESI 4&5) are often faced with long wait times as care for higher acuity patients is expedited, and because of this, some patients will choose to leave the EC to seek care elsewhere. The number of patients who leave the EC prior to contact with a provider is identified as the left without being seen rate (LWBS). The Harris Health System plans to implement a physician-in-triage model to address these challenges. We expect that these triage providers will be able to assess patients quickly, identify patients with low acuity complaints and refer them to same-day access clinics that would be able to address their care needs. The outcome measures for the project will be the LWBS rates for patients triaged to ESI 4&5.

We expect that this project will improve the overall efficiency of the healthcare system by helping patients with non-urgent conditions receive appropriate care in a more cost effective setting. We also expect that the time from arrival to provider contact will be reduced under this new model, and thus reducing the percentage of patients that choose to leave the EC prior to provider contact (LWBS rate). Because the provider-in-triage model is a new service for the Harris Health System, process milestones P-1 and P-2 were selected in order to plan for the program and establish baseline metrics. In DY2, we will complete a full project plan with written guidelines for the triage provider to follow. In DY3, we will establish baseline LWBS rates for these ESI 4&5 patients and expected target reductions in LWBS rates over DY4-5.

Process Milestones:
- DY2: P-1
- DY3: P-2

Outcome Improvement Targets:
- DY4 and DY5: IT-9.4 – Reduce Left Without Being Seen (LWBS) rates for ESI Level 4 and 5 patients
  o Improvement Targets: TBD

Rationale:
In 2010, over 40% of Harris County ER visits by Harris County residents were primary care related, these include visits for conditions that are non-urgent, primary care treatable, and primary care preventable. The average cost to treat these patients in the ER versus a primary care setting was approximately $800 per visit for all age groups. Referring patients with primary care
treatable conditions to proximate same day clinics can help to reduce costs of care for the affected individual patients, freeing resources and improving efficiency for patients who need emergent care.

**Outcome Measure Valuation:**
This project will improve patient throughput times for patients appropriately utilizing emergency room services, and improve the overall efficiency of the healthcare system by helping patients with non-urgent conditions receive appropriate care in a more cost effective setting. The value of the project is based on cost savings associated with a reduction in the utilization of emergency services by non-urgent patients. Referring patients with primary care treatable conditions to proximate walk-in clinics can also help to reduce costs of care for the affected individual patients, freeing resources and improving efficiency for patients who need emergent care.

We expect that this project will improve the overall efficiency of the healthcare system by helping patients with non-urgent conditions receive appropriate care in a more cost effective setting. We also expect that the time from arrival to provider contact will be reduced under this new model, and thus reducing the percentage of patients that choose to leave the EC prior to provider contact (LWBS rate). Because the provider-in-triage model is a new service for the Harris Health System, process milestones P-1 and P-2 were selected in order to plan for the program and establish baseline metrics. In DY2, we will complete a full project plan with written guidelines for the triage provider to follow. In DY3, we will establish baseline LWBS rates for these ESI 4&5 patients and expected target reductions in LWBS rates over DY4-5.

In addition to the value of improved care for these patients, we also expect the project to have a cost savings associated with a reduction in the utilization of emergency services by non-urgent patients. Referring patients with primary care treatable conditions to proximate walk-in clinics can also help to reduce costs of care for the affected individual patients, freeing resources and improving efficiency for patients who need emergent care.
<table>
<thead>
<tr>
<th>13335104.3.17</th>
<th>IT-9.4</th>
<th>Reduce LWBS rate for ESI Level 4 and 5 patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Harris Health System</td>
<td>13335104</td>
</tr>
<tr>
<td><strong>Related Category 2 Projects:</strong></td>
<td></td>
<td>13335104.2.3</td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td></td>
<td>To be established in DY3.</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-1]: Complete project plan</strong></td>
<td><strong>Process Milestone 2 [P-2]: Establish baseline LWBS rate for ESI level 4 and 5 patients</strong></td>
<td><strong>Outcome Improvement Target 1 [IT-9.4]: Reduce LWBS rate for patients triaged to ESI Level 4 and 5 Improvement Target: TBD</strong></td>
</tr>
<tr>
<td>Data Source: Project plan document.</td>
<td>Data Source: EHR</td>
<td>Data Source: EHR</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $288,935</td>
<td>Process Milestone 2 Estimated Incentive Payment: $334,913</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $537,419</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $288,935</td>
<td>Year 3 Estimated Outcome Amount: $334,913</td>
<td>Year 4 Estimated Outcome Amount: $537,419</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add outcome amounts over DYs 2-5): $2,446,399</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Harris County Hospital District Ben Taub General Hospital
Pass 2
**Title of Outcome Measure (Improvement Target):** IT-10.1 Quality of Life

**Performing Provider/TPI:** Harris Health System/133355104

**Unique RHP Outcome ID:** 133355104.3.18 / Pass 2

**Outcome Measure Description:**
As Performing Provider for project 133355104.1.13, Harris Health System decided to measure improvement in quality of life is the Short Form Health Survey (SF-12). This is an outcome domain OD-10 Quality of Life/Functional Status Measure that is specifically IT-10.1 Quality of Life. The performing provider will be the physical or occupational therapist providing services.

This outcome measure was selected because it is able to be used on individuals from a wide range of age groups and treatment groups with a variety of diseases and conditions. In addition, this outcome measure is available in over 140 translations. This tool is evidence based and validated for a wide range of diagnostic groups that are routinely seen in outpatient services.

The SF-12 is a multipurpose, 12-item survey that measures eight domains of health: physical functioning, role limitations due to physical health, bodily pain, general health perceptions, vitality, social functioning, role limitations due to emotional problems, and mental health. It yields scale scores for each of these eight health domains, and two summary measures of physical and mental health: the Physical Component Summary (PCS) and Mental Component Summary (MCS). Patients will complete the Short Form Health Survey (SF-12) upon initial evaluation and upon discharge from Physical or Occupational Therapy to measure the patient’s perceived quality of life before and after therapy intervention. With this outcome measure, improvement in quality of life will be demonstrated by an increased score at discharge from the score at initial evaluation. The scores will vary from patient to patient, but an average score is above a 50. The determined outcome improvement target for each year and patient will be to improve the score to greater than 50 at discharge from physical and occupational therapy.

**Process Milestones:**
- **DY2:** P-4
- **DY3:** P-2
- **DY4:** P-5

**Outcome Improvement Target(s) for each year:**
- **DY4:**
  - IT-10.1 Quality of Life
  - Improve quality of life (QOL) scores to greater than 50 at discharge from therapy for at least 10% of the patients seen in DY4
- **DY5:**
  - IT-10.1 Quality of Life
  - Improve quality of life (QOL) scores to greater than 50 at discharge from therapy for at least 20% of the patients seen in DY5

**Rationale:**
Milestones P-2 and P-4 were chosen to determine the baseline Quality of Life data for the population served and design a method to organize data and determine appropriate interventions to improve Quality of Life in order to determine the outcome improvement targets for the
specific population served in years 3, 4, and 5. Milestone P-5 was chosen to ensure that the baseline data, lessons learned, and best practices be disseminate to the stakeholders and specialty providers to improve Quality of Life with improved access to care.

The average QOL score is above a 50; therefore, Improvement Targets in DY4 and DY5 aim to improve QOL scores to greater than 50 at discharge from therapy for at least 10% of the patients seen in DY4 and 20% of patients seen in DY5.

**Outcome Measure Valuation:**

This project will increase the capacity to provide outpatient physical and occupational therapy services to the underserved areas of Harris County, primarily low-income, uninsured and Medicaid populations. The expanded Outpatient Physical Therapy and Occupational Therapy (PT and OT) services will be targeted to populations who are at risk for impairments in activities of daily living resulting from a lack of access to specialty care. The project will improve access by providing an additional 12 PT and OT providers to the Rehabilitation Services department and by adding additional outpatient therapy treatment space near the referring clinics, facilitating an increase in the number of patients seen per month by specialty Physical and Occupational Therapy services of 510 patients. The project will result in improved quality of life by persons served, measured by a standard health survey. The outcome measure goals of this project are to increase the quality of life measure for 10% of patients in DY4 and 20% of patients in DY5. The added value to the improved quality of life per patient in this project was the basis for the valuation of this particular outcome measure.
<table>
<thead>
<tr>
<th>133355104.3.18</th>
<th>3.IT-10.1</th>
<th>Quality of Life</th>
<th>133355104.1.13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Related Category 1 or 2 Projects:</strong></td>
<td></td>
<td>Harris Health System</td>
<td></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td></td>
<td>To be established in DY2.</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong>&lt;br&gt;(10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-2]:</strong> Establish baseline scores for quality of life using SF-12&lt;br&gt;Data Source: EHR and SF-12 scores from initial evaluation and discharge.</td>
<td><strong>Process Milestone 3 [P-5]:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders&lt;br&gt;Data Source: EHR, baseline data and PDSA</td>
<td><strong>Outcome Improvement Target 1 [IT 10.1]:</strong> Quality of life; Patient self-reported scores on the SF-12&lt;br&gt;Improvement Target: Improve quality of life (QOL) scores to greater than 50 at discharge from therapy for at least 10% of the patients seen in DY4&lt;br&gt;Data Source: EHR and SF-12 scores from initial evaluation and discharge.</td>
<td><strong>Outcome Improvement Target 2 [IT 10.1]:</strong> Quality of life; Patient self-reported scores on the SF-12&lt;br&gt;Improvement Target: Improve quality of life (QOL) scores to greater than 50 at discharge from therapy for at least 20% of the patients seen in DY5&lt;br&gt;Data Source: EHR and SF-12 scores from initial evaluation and discharge.</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (<em>maximum amount</em>): $214,155</td>
<td>Process Milestone 3 Estimated Incentive Payment: $496,467</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $796,657</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $1,905,049</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-4]:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities&lt;br&gt;Data Source: EHR and SF-12 scores from initial evaluation and discharge.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $214,155</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong>&lt;br&gt;(add incentive payments amounts from each milestone/outcome improvement target): $428,310</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong>&lt;br&gt;$496,467</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong>&lt;br&gt;$796,657</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong>&lt;br&gt;$1,905,049</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**<br>(*add outcome amounts over DYs 2-5*): $3,626,484
Title of Outcome Measure (Improvement Target): IT 6.2- Other: Percent improvement over baseline of Patient Satisfaction scores

Unique RHP outcome identification number(s): 133355104.3.19 / Pass 2
Performing Provider Name/TPI: Harris Health System / 133355104

Outcome Measure Description:
IT 6.2 will measure improvement in the overall mean score for patient satisfaction over time using the standard same day access clinic survey supplied by Press Ganey and approved by HHSC.

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health System health centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For Casa de Amigos Health Center, there were 107 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. As a result, patient satisfaction scores reported by Press Ganey can be greatly improved. From November 2011-October 2012 at Casa de Amigos Health Center, the mean score for “Ease of scheduling appointments” was 74.7.

Same day access clinic operations will differ from current health centers, resulting in a need for a customized survey. The baseline patient satisfaction score at Casa same day access clinic will be established in DY3 after a new, custom survey is developed and implemented through Press Ganey for same day access clinic usage.

Process Milestones:
- DY2: P-1; P-5
- DY3: P-2; P-4

Outcome Improvement Target(s) for each year:

- DY4:
  - IT 6.2- 0.5% improvement over baseline of patient satisfaction for overall mean survey score
- DY5:
  - IT 6.2- 1% improvement over baseline of patient satisfaction for overall mean survey score

Rationale:
P-1 was chosen to ensure that all necessary stakeholders are consulted to develop strategies and processes necessary to reach patient satisfaction goals. Moreover, a new, customized patient satisfaction survey will be developed for same day access clinics in
partnership with Press Ganey. P-5 will also be approached in DY2. We plan to share finding and lessons from project planning with internal and external stakeholders. In DY3, P-2 will produce a baseline score at the new same day access clinic based on available performance. In DY3, we will also conduct PDSA cycles for P-4 to ensure that strategies and processes for identified interventions are effective.

IT- 6.2 will be measured beginning in DY4 to allow for time and resources needed to purchase lease space, hire staff, and operate the same day access clinic for patient care and successful survey calculation. Improvement targets were chosen with the expectation to reach patient satisfaction goals gradually to coincide with improvements in operations at the clinic. Based on Harris Health System’s historic Press Ganey patient satisfaction scores and the volume of patients served, we believe the percent improvement goals suggested are both challenging and meaningful.

Outcome Measure Valuation:
This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic’s capacity to provide primary care services, including laboratory point-of-care testing, along with timely referrals for specialty care, imaging and other needed services within the Harris Health System network. The clinic can ultimately care for the episodic primary care needs of over ten thousand patients annually, and refer new patients with chronic disease management needs to one of the NCQA certified medical home clinics that are operated by Harris Health. In addition, the availability of same day primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

Currently, some patients do not rate Harris Health positively due to the fact that waitlists to see providers are at times sixty plus days because of the high demand and limited providers. Because of the current back-log of patients, Harris Health System assures that by building a Casa de Amigos Same Day Access clinic, we will meet the basic needs of thousands of more patients in a timely manner, giving Harris Health the ability to survey potentially 31,000 additional patients between DY3 and DY5, increasing the patient satisfaction score. From 2011 to 2012, Harris Health System’s existing Ambulatory Care Health Centers patient satisfaction score improved 2% across all centers combined, leading us to believe that the goals we have established will be both challenging and meaningful upon establishing a baseline. For this project, Harris Health will implement a new survey tool for a different environment in which care will be provided; therefore, we wanted to keep the goals achievable as this will be a new endeavor for our system in terms of same day clinics and patient satisfaction.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133355104.1.14</th>
<th>133355104</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>To be established in DY3</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data Source: EHR; Business Intelligence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Process Milestone 1 Estimated Incentive Payment <em>(maximum amount)</em>: $419,558</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-5]:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>Data Source: EHR; reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Process Milestone 2 Estimated Incentive Payment: $419,558</td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td><strong>Process Milestone 3 [P-2]:</strong> Establish baseline patient satisfaction score at Casa de Amigos same day access clinic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data Source: Press Ganey</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Process Milestone 3 Estimated Incentive Payment: $486,323</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 4 [P-4]:</strong> Conduct Plan Do Study Act (PDCA) cycles to improve intervention activities</td>
<td>Data Source: Report documentation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Process Milestone 4 Estimated Incentive Payment: $486,323</td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
<td><strong>Outcome Improvement Target 1 [IT-6.2]:</strong> Percent improvement over baseline of patient satisfaction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improvement Target: Increase score by 0.5% above baseline</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data Source: Press Ganey</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $1,560,756</td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong>&lt;br&gt;(10/1/2015 – 9/30/2016)</td>
<td><strong>Outcome Improvement Target 2 [IT-6.2]:</strong> Percent improvement over baseline of patient satisfaction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improvement Target: Increase score by 1% above baseline</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data Source: Press Ganey</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $3,732,243</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong>&lt;br&gt;(add incentive payments amounts from each milestone/outcome improvement target): $839,116</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong>&lt;br&gt;$972,645</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong>&lt;br&gt;$1,560,756</td>
</tr>
<tr>
<td><strong>Year 5 Estimated Outcome Amount:</strong>&lt;br&gt;$3,732,243</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong>&lt;br&gt;<em>(add outcome amounts over DYS 2-5)</em>: $7,104,761</td>
<td></td>
</tr>
</tbody>
</table>
**Title of Outcome Measure (Improvement Target):** IT-7.8 Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider. (Standalone measure)

**Unique RHP outcome identification number:** 133355104.3.20 / Pass 2

**Performing Provider name/TPI:** Harris Health System / TPI 133355104

**Outcome Measure Description:**

Process Milestones
- DY2: P-1; P-5
- DY3: P-2

Outcome Improvement Milestones and Targets:
- DY4:
  - IT-7.8 Chronic Disease Patients Accessing Dental Services: Percentage of patients with diabetes accessing dental services following referral by their medical provider. Target: 5% increase over baseline
- DY5:
  - IT-7.8 Chronic Disease Patients Accessing Dental Services: Percentage of patients with diabetes accessing dental services following referral by their medical provider. Target: 7% increase over baseline

**Rationale**
In DY2, we will focus on process milestone P-1 chosen to ensure that all necessary stakeholders are consulted to develop strategies and processes necessary to reach patient satisfaction goals. P-5 will also be completed in DY2 as we share findings and lessons from project planning with internal and external stakeholders. In DY3, we will establish the baseline rate to be used for measuring and reporting purposes in DY4 and DY5. During DY4 and DY5, we will begin to measure improvement targets. Our goal is to increase the percentage of patients with diabetes who access our dental services following a referral. We chose a low target because the demand is greater than the access.

**Outcome Measure Valuation:**
There is limited access for oral health, particularly for the low-income, uninsured, and Medicaid populations. Oral health is vital in disease prevention. Bad oral health care increases the risk of heart disease, diabetes and stroke. By adding and expanding dental services to six sites, we will be increasing access to oral health services for the underserved in Harris County, and thereby helping to reduce disparities. The expanded services in Harris Health clinics can ultimately address the routine dental care needs of over ten thousand patients, or 26,050 additional visits, annually. Treating cavities and other oral health problems will assist in providing healthcare cost savings by preventing or mitigating the effects of other chronic diseases, with a specific focus on the diabetic population.
### Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider.

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133355104.1.15</th>
<th>Harris Health System</th>
<th>133355104</th>
</tr>
</thead>
</table>

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR; Business Intelligence</td>
<td><strong>Process Milestone 3 [P-2]:</strong> Establish baseline rates of unduplicated patients with diabetes accessing dental services at primary care sites following referral by their medical provider. Data Source: EMR</td>
<td><strong>Outcome Improvement Target 1 [IT-7.8] Chronic Disease Patients Accessing Dental Services: Percentage of patients with diabetes accessing dental services following referral by their medical provider. Improvement Target: 5% increase over baseline Data Source: EMR</strong></td>
<td><strong>Outcome Improvement Target 2 [IT-7.8] Chronic Disease Patients Accessing Dental Services: Percentage of patients with diabetes accessing dental services following referral by their medical provider. Improvement Target: 7% increase over baseline Data Source: EMR</strong></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $382,449</td>
<td>Process Milestone 3 Estimated Incentive Payment: $886,617</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $1,422,711</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $3,402,135</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-5]:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR; Business Intelligence; reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $382,449</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2 Estimated Outcome Amount:** (add incentive payments amounts from each milestone/outcome improvement target): $ 764,898

**Year 3 Estimated Outcome Amount:** $886,617

**Year 4 Estimated Outcome Amount:** $1,422,711

**Year 5 Estimated Outcome Amount:** $3,402,135

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $6,476,361
Harris County Hospital District Ben Taub General Hospital
Pass 3
**Title of Outcome Measure (Improvement Target):** IT-9.2 ED Appropriate Utilization

**Unique RHP outcome identification number:** 133355104.3.21 / Pass 3

**Outcome Measure Description:**
OD-9:IT-9.2

- **Process Milestones selected:**
  o DY2: (P-1) Project planning
  o DY3: (P-2) Establish baseline rates of ED utilization

- **Improvement targets selected:**
  o DY4: (IT-9.2) Improvement Target: 5% reduction below baseline
  o DY5: (IT-9.2) Improvement Target: 10% reduction below baseline

**Rationale:**

Because of transportation and logistic challenges, many homebound patients are using the ED as their source of primary care, the wrong care in the wrong (and most expensive) place. By providing continuity care in these patients’ homes, we will reserve the ED for appropriate use. With 24 hour phone access and (limited) capacity for urgent visits for heart failure or COPD exacerbations, even some otherwise “appropriate” use may be curtailed. This is why the house calls program has chosen to measure ED utilization in Category 3.

We will use the historical data from each individual as their own baseline, assessing the number of ED visits in the prior months to calculate their ED visit/pt year use. DY3 will be utilized to acquire this data. We will then continue to monitor ED visits and expect a 5% decrease in DY4 and 10% decreased in the overall ED visit/pt year rate in DY5.

**Outcome Measure Valuation:**

This project will expand the House Calls Program in order to improve access, maximize independence, and realize cost savings by providing comprehensive, coordinated, multidisciplinary primary care at home to a population of patients that are homebound or have difficulties getting to clinic visits. The geographical challenges of the region will be addressed by a logistics approach using regional cohorting, and the house calls model will create patient-centered, coordinated primary care delivery that improves patient satisfaction and health outcomes, reduces unnecessary services, and builds on the accomplishments of our existing health care system. The present house calls team is very modest, delivering care to 180 housebound patients. By the end of the demonstration period, the two interdisciplinary teams including physicians, nurse practitioners, social workers, pharmacists, therapists, and integrated call center and support team are expecting to manage 1,000 patients in their homes and make approximately 5,000 house calls in the year. The expected impact will be several thousand fewer ambulance rides, 2,800 fewer EC visits, 1,000 fewer admissions, resulting in millions of dollars in cost avoidance and realized savings.-By decreasing inappropriate ED utilization by established house calls patients to 10% below baseline by DY5, there are significant cost savings that add value to this project. It must also be noted that the overall satisfaction of the patient will increase, as unnecessary ED visits and long waits are avoided.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133355104.1.16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>TBD</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</strong>&lt;br&gt;Data Source: Project plans and meetings&lt;br&gt;&lt;br&gt;Process Milestone 1 Estimated Incentive Payment: $1,504,357</td>
<td><strong>Process Milestone 2 [P-2]: Establish Baseline</strong>&lt;br&gt;Data Source: EMR</td>
<td><strong>Outcome Improvement Target 1 [IT-9.2]: ED appropriate utilization</strong>&lt;br&gt;Improvement Target: 5% decrease below baseline of inappropriate ED utilization per pt year&lt;br&gt;Data Source: EMR&lt;br&gt;&lt;br&gt;Outcome Improvement Target 1 Estimated Incentive Payment: $666,578</td>
<td><strong>Outcome Improvement Target 3 [IT-9.2]: ED appropriate utilization</strong>&lt;br&gt;Improvement Target: 10% decrease below baseline of inappropriate ED utilization per pt year&lt;br&gt;Data Source: EMR&lt;br&gt;&lt;br&gt;Outcome Improvement Target 2 Estimated Incentive Payment: $1,586,826</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: $1,504,357 | Year 3 Estimated Outcome Amount: $427,054 | Year 4 Estimated Outcome Amount: $666,578 | Year 5 Estimated Outcome Amount: $1,586,826 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $4,184,815*
<table>
<thead>
<tr>
<th>13355104.3.22 REMOVED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): IT-7.4 Topical Fluoride application (Non-Standalone measure)

Unique RHP outcome identification number(s): 133355104.3.23/ Pass 3

Performing Provider name/TPI: Harris Health System/133355104

Outcome Measure Description:

Process Milestones:
- DY2:
  - P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2 Establish baseline rates of children receiving fluoride application within the Harris Health System pediatric dental clinics

Improvement Milestones and Targets:
- DY4:
  - IT-7.4 Topical Fluoride application
    Target: 30% increase from baseline of children receiving fluoride application
- DY5:
  - IT-7.4 Topical Fluoride application
    Target: 50% increase from baseline of children receiving fluoride application

Rationale:
In DY2, we will focus on process milestone P-1 to allow Harris Health to plan for the implantation of pediatric dental clinics. In DY3, we will establish the baseline rate to be used for measuring and reporting purposes in DY4 and DY5. During DY4 and DY5, we will begin to measure improvement targets. Our goal is to increase the number of fluoride applications to prevent more costly adverse effects.

Outcome Measure Valuation:
The goal is to increase the number of children accessing dental services. Currently, Harris Health System only offers adult oral health care at some of our centers. Oral health services are essential in preventing gum disease and cavities, which have been linked to other diseases such as diabetes and heart stroke. Access to oral health services is especially important for children and adolescents, since dental problems may affect quality of life and ability to succeed. Children from lower-income families often do not receive timely treatment for tooth decay, and they are more likely to suffer from chronic conditions (National Center for Chronic Disease Prevention and Health Promotion). Treating cavities and other oral health problems at an early age has potential cost savings by preventing other chronic diseases that may come later in life. Fluoride varnish helps stop cavities that have started and helps prevent new ones. Therefore, increasing
the percentage of children that receive fluoride applications will decrease the risk of more costly oral health problems and treatments later in life.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133355104.1.17</th>
<th>133355104</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IT-7.4</strong></td>
<td>Topical Fluoride application</td>
<td>Harris Health System</td>
</tr>
</tbody>
</table>

| Starting Point/Baseline: | TBD | 133355104.3.23 |

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]</strong>: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 2 [P-2]</strong>: Establish baseline rates of children receiving fluoride application within the Harris Health System pediatric dental clinics</td>
<td><strong>Outcome Improvement Target 1</strong> [IT-7.4] Topical Fluoride application: Percentage of children, age 6mos-20 years, who received a fluoride varnish application during the measurement period. Improvement Target: 30% increase from baseline of children receiving fluoride application Data Source: EMR</td>
<td></td>
</tr>
<tr>
<td>Data Source: Planning Documentation</td>
<td>Process Milestone 2 Estimated Incentive Payment: $246,076</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $381,068</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment:</td>
</tr>
<tr>
<td><strong>Process Milestone 1 Estimated Incentive Payment (maximum amount):</strong> $971,967</td>
<td></td>
<td><strong>Outcome Improvement Target 1</strong> [IT-7.4] Topical Fluoride application: Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period. Improvement Target: 50% increase from baseline of children receiving fluoride application Data Source: EMR</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $971,967</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $246,076</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $381,068</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $907,154</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $2,506,265*
**Title of Outcome Measure (Improvement Target):** IT- 8.2 Percentage of Low Birth-Weight Births

**Unique RHP outcome identification number(s):** 133355104.3.24 / Pass 3  
**Performing Provider Name/TPI:** Harris Health System / 133355104

**Outcome Measure Description:**  
IT- 8.2 will be defined as babies born weighing <2,500 grams at birth (numerator) and will measure the percentage of low birth-weight births among those patients who have completed the OB Navigation program by the time of delivery at a Harris Health System hospital. Harris Health System is the performing provider for this project and Category 3 outcome measure.  
Harris County’s low birth weight rate (8.8 %) for the same year is higher than the Healthy People 2020 goal of 7.8% and higher than the 2010 national average of 8.15%. Moreover, the percentage of low birth-weight births at the Harris Health System (LBJ General Hospital and Ben Taub General Hospital combined) for 2011 was 9.9%. Low birth-weight rate is also a Healthy People 2020 objective. IT-8.2 will measure the percentage of low birth-weight births among those patients who have completed the OB Navigation program (received the intervention) by the time of delivery at a Harris Health System hospital. The definition of “program completion” will be determined during the DY2 planning period. While we know that the 2011 percentage was 9.9%, we will collect more recent baseline data during DY3 for the low birth-weight percentage. The DY3 baseline will be used for performance measurement.

**Process Milestones:**  
- DY2: P-1; P-3; P-5  
- DY3: P-2; P-3

**Outcome Improvement Target(s) for each year:**  
- DY4:  
  - IT- 8.2 Percentage of Low Birth-Weight Births  
    - Of those patients who received the intervention, decrease the percentage of babies born weighing <2,500 grams at birth to less than DY2 baseline  
- DY5:  
  - IT- 8.2 Percentage of Low Birth-Weight Births  
    - Of those patients who received the intervention, decrease the percentage of babies born weighing <2,500 grams at birth to a rate to be determined

**Rationale:**  
Process milestones –P-1 through P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor timeliness of prenatal and postnatal care within the Harris Health System. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3. In DY3 we will establish baseline percentage with P-2. P-5 will be approached in DY2, after the initial gap analysis is completed. Lessons learned will be shared with the Region and stakeholders. Improvements targets were placed in DY4 and 5 based on the timeframe allowed to put in place the proper resources and processes needed to collect data. The improvement target goal will be to achieve a low birth-weight percentage below the baseline percentage to be determined in in DY3. The performance during DY4, whether high or low, will dictate an appropriate
improvement target goal for DY5. It is also important to note that the outcome measure being addressed may be affected by social determinants other than prenatal encounters with navigators and providers. For instance, psychosocial, mental health, demography trends, and behavioral issues will affect the incidence of low birth-weight births. In addition, the long timeframe needed to realize perinatal outcomes results for full-term pregnancies was considered when determined improvement targets. Patients in the project will be enrolled at the beginning of pregnancy and will need to be followed over time.

**Outcome Measure Valuation:**

The goal of this project is to utilize community health workers, case managers, social workers, and nurses as a comprehensive patient navigation team that will provide enhanced care coordination, community outreach, social support and culturally competent care to high-risk obstetrics patients throughout their pregnancy. The estimated number of high risk cases at Harris Health on an annual basis is over 2,000. All of those cases will be targeted by this program, with a goal to decrease the percentage of low birth-weight births among patients who complete the program and deliver at Harris Health System. Of those patients who receive patient navigation services, the goal is to decrease the percentage of babies born weighing <2,500 grams at birth to less than DY2 baseline.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Process Milestone 4 [P-3]: Develop and test data systems</th>
<th>Outcome Improvement Target 1 [IT-8.2]: Percentage of Low Birth-Weight Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: EHR reports</td>
<td>Data Source: EHR; Business Intelligence</td>
<td>Improvement Target: Of those patients who received the intervention, decrease the percentage of babies born weighing &lt;2,500 grams to less than DY3 baseline percentage</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $894,031</td>
<td>Process Milestone 4 Estimated Incentive Payment: $363,678</td>
<td>Data Source: EHR; Business Intelligence</td>
</tr>
<tr>
<td>Process Milestone 2 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>Process Milestone 5 [P-2]: Establish baseline rate- total percentage of babies born weighing &lt;2,500 grams at birth at Harris Health System hospitals</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $1,359,299</td>
</tr>
<tr>
<td>Data Source: EHR; Business Intelligence; reports</td>
<td>Data Source: EHR; Business Intelligence</td>
<td>Process Milestone 5 Estimated Incentive Payment: $363,678</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $592,658</td>
<td>Process Milestone 3 Estimated Incentive Payment: $889,031</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $1,788,062</td>
<td>Year 3 Estimated Outcome Amount: $727,356</td>
<td>Year 4 Estimated Outcome Amount: $1,359,299</td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount: $3,137,411</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $7,012,128</td>
<td>Year 5 Estimated Outcome Amount: $3,137,411</td>
<td>Year 5 Estimated Outcome Amount: $3,137,411</td>
</tr>
</tbody>
</table>
**Title of Outcome Measure (Improvement Target):** IT-1.20 Management of International Normalized Ratio (INR) for patients receiving anticoagulation monitoring

**Unique Project Identification number:** 133355104.3.25/ Pass 3  
**Performing Provider Name/TPI#:** Harris Health System/133355104

**Outcome Measure Description**  
IT-1.20 will measure the percentage of patients with at least 2 consecutive INRs within goal range (goal is specific for each patient). We will divide the number of patients with INR at goal for 2 consecutive visits by the total number of patients with monitored INR to establish the baseline percentages within the Harris Health System.

**Process Milestones:**
- **DY2: P-2**

**Outcome Improvement Target(s) for each year:**
- **DY3:**
  - IT-1.20 will measure the percentage of patients with at least 2 consecutive INRs within goal range (goal is specific for each patient).
    - 35% of all patients seen at Harris Health will have at least 2 consecutive INRs at goal by the end of DY3
- **DY4:**
  - IT-1.20 will measure the percentage of patients with at least 2 consecutive INRs within goal range (goal is specific for each patient).
    - 40% of all patients seen at Harris Health will have at least 2 consecutive INRs at goal by the end of DY3
- **DY5:**
  - IT-1.20 will measure the percentage of patients with at least 2 consecutive INRs within goal range (goal is specific for each patient).
    - 50% of all patients seen at Harris Health will have at least 2 consecutive INRs at goal by the end of DY3

**Rationale:**
Process milestone P-2 was chosen to determine the percentage of patients with at least 2 consecutive INRs within goal range (goal is specific for each patient). We will divide the number of patients with INRs at goal for 2 consecutive visits by the total number of patients being monitored to establish the baseline percentages within the Harris Health System. Reports run from EPIC® (our electronic medical record system) will allow us to capture the baseline data needed and this will be completed in DY2. Improvement targets were placed in DY3 thru DY5 and are on contingent on our ability to accurately establish the baseline rate in DY2. Improvement target goals will be determined after baseline percentage is set in DY2. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

**Outcome Measure Valuation:**

In recent years there has been an increasing shift in warfarin therapy management from standard care by a physician to dedicated anticoagulation clinic models. Pharmacist-managed
anticoagulation clinics provide patients with expert care, frequent monitoring, and education to ensure optimal outcomes and increased patient safety. Education and patient involvement have been shown to increase compliance, leading to improved patient outcomes as a result of more frequent monitoring. This project significantly enhances our existing delivery system by increasing availability of persons qualified to manage acute and chronic care needs as related to anticoagulation management. This increase in availability not only allows for timely and more frequent patient follow up but also decreases the risk of potential complications which may require management in the acute care setting, resulting in a measurable reduction in the number of hospital admissions and emergency room visits secondary to the warfarin complications rate.
### Process Milestone 1

- **P-2** Establish baseline rates for percentage of patients seen by clinical pharmacists with at least 2 consecutive INRs
  
  **Data Source:** EHR

**Estimated Incentive Payment (maximum amount):** $1,327,433

### Outcome Improvement Target 1

**[IT-1.20]: Management of INR for patients receiving anticoagulation monitoring**

- **Improvement Target:** 20% increase from baseline of the number of patients seen by clinical pharmacists with at least 2 consecutive INRs at goal.
  
  **Data Source:** EHR

**Estimated Incentive Payment:** $204,025

### Outcome Improvement Target 2

**[IT-1.20]: Management of INR for patients receiving anticoagulation monitoring**

- **Improvement Target:** 30% increase from baseline of the number of patients seen by clinical pharmacists with at least 2 consecutive INRs at goal.
  
  **Data Source:** EHR

**Estimated Incentive Payment:** $300,995

### Outcome Improvement Target 3

**[IT-1.20]: Management of INR for patients receiving anticoagulation monitoring**

- **Improvement Target:** 40% increase from baseline of the number of patients seen by clinical pharmacists with at least 2 consecutive INRs at goal.
  
  **Data Source:** EHR

**Estimated Incentive Payment:** $716,536

### Year 2 Estimated Outcome Amount:

- **(target):** $1,327,433

### Year 3 Estimated Outcome Amount:

- **(target):** $204,025

### Year 4 Estimated Outcome Amount:

- **(target):** $300,995

### Year 5 Estimated Outcome Amount:

- **(target):** $716,536

### TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD

*(add outcome amounts over DYs 2-5): $ 2,548,989*
Title of Outcome Measure (Improvement Target): IT-2.13 Other Admissions Rate

Unique Project Identification number: 133355104.3.26/ Pass 3
Performing Provider Name/TPI#: Harris Health/133355104

Outcome Measure Description:
IT-2.13 will be defined as other admissions rates and will measure the number of hospital admissions and emergency room visits secondary to warfarin complications at Harris Health System.

Process Milestones:
- DY2: P-2

Outcome Improvement Target(s) for each year:
- DY3:
  - IT-2.13 Other admissions rate: hospital admissions and emergency room visits secondary to warfarin complications
    - 10% reduction from baseline in the number of hospital admissions and emergency room visits secondary to warfarin complications rate at the end of DY3
- DY4:
  - IT-2.13 Other admissions rate: hospital admissions and emergency room visits secondary to warfarin complications
    - 20% reduction from baseline in the number of hospital admissions and emergency room visits secondary to warfarin complications rate at the end of DY4
- DY5:
  - IT-2.13 Other admissions rate: hospital admissions and emergency room visits secondary to warfarin complications
    - 40% reduction from baseline in the number of hospital admissions and emergency room visits secondary to warfarin complications rate at the end of DY5

Rationale:
Process milestone P-2 was chosen to determine baseline rates for hospital admissions and emergency room visits secondary to warfarin complications within the Harris Health System. Reports run in EPIC® (our electronic medical record system) will allow us to capture the baseline data needed and this will be completed in DY2. Improvement targets were placed in DY3 thru DY5 and are contingent on our ability to accurately establish baseline rates in DY2. Improvement target goals will be determined after baseline rates are set in DY2. The baseline rates, whether high or low, will dictate an appropriate improvement target goal.

Outcome Measure Valuation:
In recent years there has been an increasing shift in warfarin therapy management from standard care by a physician to dedicated anticoagulation clinic models. Pharmacist-managed anticoagulation clinics provide patients with expert care, frequent monitoring, and education to ensure optimal outcomes and increased patient safety. Education and patient involvement have been shown to increase compliance, leading to improved patient outcomes as a result of more
frequent monitoring. This project significantly enhances our existing delivery system by increasing availability of persons qualified to manage acute and chronic care needs as related to anticoagulation management. This increase in availability not only allows for timely and more frequent patient follow up but also decreases the risk of potential complications which may require management in the acute care setting, resulting in a measurable reduction in the number of hospital admissions and emergency room visits secondary to the warfarin complications rate.
### Process Milestone 1 [P-2]: Establish baseline rates for hospital admissions and emergency room visits secondary to warfarin complications

**Data Source:** EHR

**Estimated Incentive Payment (maximum amount):** $1,327,433

### Outcome Improvement Target 1 [IT-2.13 Other Admissions Rate]

**Improvement Target:** 5% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications

**Data Source:** EHR, Claims

**Estimated Incentive Payment:** $204,025

### Outcome Improvement Target 2 [IT-2.13 Other Admissions Rate]

**Improvement Target:** 10% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications

**Data Source:** EHR, Claims

**Estimated Incentive Payment:** $300,995

### Outcome Improvement Target 3 [IT-2.13 Other Admissions Rate]

**Improvement Target:** 15% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications

**Data Source:** EHR, Claims

**Estimated Incentive Payment:** $716,536

### Related Category 1 or 2 Projects:

**Starting Point/Baseline:** 133355104.2.5

<table>
<thead>
<tr>
<th>Year</th>
<th>Outcome Improvement Target 1 [IT-2.13 Other Admissions Rate]</th>
<th>Outcome Improvement Target 2 [IT-2.13 Other Admissions Rate]</th>
<th>Outcome Improvement Target 3 [IT-2.13 Other Admissions Rate]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>Improvement Target: 5% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications (Data Source: EHR)</td>
<td>Improvement Target: 10% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications (Data Source: EHR)</td>
<td>Improvement Target: 15% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications (Data Source: EHR)</td>
</tr>
<tr>
<td>Year 3</td>
<td>Improvement Target: 5% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications (Data Source: EHR, Claims)</td>
<td>Improvement Target: 10% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications (Data Source: EHR, Claims)</td>
<td>Improvement Target: 15% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications (Data Source: EHR, Claims)</td>
</tr>
<tr>
<td>Year 4</td>
<td>Improvement Target: 5% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications (Data Source: EHR, Claims)</td>
<td>Improvement Target: 10% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications (Data Source: EHR, Claims)</td>
<td>Improvement Target: 15% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications (Data Source: EHR, Claims)</td>
</tr>
<tr>
<td>Year 5</td>
<td>Improvement Target: 5% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications (Data Source: EHR, Claims)</td>
<td>Improvement Target: 10% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications (Data Source: EHR, Claims)</td>
<td>Improvement Target: 15% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications (Data Source: EHR, Claims)</td>
</tr>
</tbody>
</table>

### Year 2 Estimated Outcome Amount:

- (target): $1,327,433

### Year 3 Estimated Outcome Amount:

- $204,025

### Year 4 Estimated Outcome Amount:

- $300,995

### Year 5 Estimated Outcome Amount:

- $716,536

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYS 2-5):** $2,548,989
**Title of Outcome Measure (Improvement Target):** IT-6.1—Patient Satisfaction

(4) patient’s involvement in shared decision making

**Unique RHP outcome identification number(s):** 133355104.3.27 / Pass 3

**Outcome Measure Description:**

IT-6.1  Percent Improvement over Baseline of Patient Satisfaction Scores related to involvement in shared decision making

**Process Milestones:**

- **DY2:**
  - P-7—Other activities not described: Determine baseline of Outpatient satisfaction scores related to shared decision making
  - P-4—Conduct Plan-Do-Study-Act cycles to improve data collection and intervention activities

- **DY3:**
  - P-4—Conduct Plan-Do-Study-Act cycles to improve data collection and intervention activities

**Outcome Improvement Targets for each year:**

- **DY3:**
  - IT-6.1: Percent Improvement over Baseline of Patient Satisfaction Scores—Increase patient satisfaction scores 5% over baseline for shared decision making

- **DY4:**
  - IT-6.1: Percent Improvement over Baseline of Patient Satisfaction Scores—Increase patient satisfaction scores 10% over baseline for shared decision making

- **DY5:**
  - IT-6.1: Percent Improvement over Baseline of Patient Satisfaction Scores—Increase patient satisfaction scores 15% over baseline for shared decision making

**Rationale:**

Process milestone P-7 was chosen to capture the degree to which providers and patients are engaged in the health promotion effort at baseline. Process milestone P-4 was chosen so that rapid ongoing improvements in the program’s effectiveness and reach can be implemented and the outcome improvement targets can be reached throughout DY3-DY5.[18, 19]

The improvement target (IT-6.1) was chosen based on evidence that patient satisfaction surveys are an acceptable proxy of quality care provision in healthcare settings.[17] The improvement in patient satisfaction will compliment the Category 2 Improvement measure. It is believed the more patients who receive health promotion through their primary care provider and medical home, the more will view this aspect of care favorably and will express satisfaction in the shared decision making activities in which they engage with their providers around the issues of health promotion and healthy eating.

**Outcome Measure Valuation:**

The goal of the this project is to develop a program for promoting increased consumption of fruits and vegetables among primary care patients through an integrated approach that
includes multi-provider and multi-modal patient education and access to a clinic-based farmer’s market. Providers in Harris Health System recognize the need to counsel patients on healthy lifestyle behavior, but are often hesitant because of the challenges patients face with compliance. This project will leverage the motivating power of the provider-patient relationship. It will equip providers with a tangible tool (prescription) to use in their counseling and will give patients a specific avenue for adoption of the recommended behavior. The goal will be to educate 1,000 patients monthly across 10 medical home sites on the health promoting benefits of fruit and vegetable intake. Evidence from studies like Dietary Approaches to Stop Hypertension have determined that diets high in fruits and vegetables can reduce blood pressure, stroke risk, and weight. It has also been shown to prevent some cancers, and diabetes. Given the high level of chronic disease in the Harris Health patient population, improved diet can have immediate positive impact on the health of our patients, and result in long-term savings in emergency and acute care costs.
### Harris Health System

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133355104.2.6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>Baseline to be determined in year 2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Process Milestone 1</strong> [P-7]: Other activities not described—Establish baseline rate of patients receiving prescriptions for healthy eating</th>
<th><strong>Process Milestone 3</strong> [P-4]: Conduct Plan-Do-Study-Act cycles to improve data collection and intervention activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: EHR report of number of prescriptions written</td>
<td>Data Source: Document weekly program assessment and outcomes and ideas for improvement</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment <em>(maximum amount)</em>: $657,161</td>
<td>Milestone 3 Estimated Incentive Payment <em>(maximum amount)</em>: $83,522</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Process Milestone 2</strong> [P-4]: Conduct Plan-Do-Study-Act cycles to improve data collection and intervention activities</th>
<th><strong>Outcome Improvement Target 4</strong> [IT-6.1]: Other outcome improvement target—Improvement Target: Increase patient satisfaction score 10% above baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Document weekly program assessment and outcomes and ideas for improvement</td>
<td>Data Source: Press Ganey administered patient satisfaction survey results</td>
</tr>
<tr>
<td>Milestone 2 Estimated Incentive Payment <em>(maximum amount)</em>: $657,162</td>
<td>Outcome Improvement Target 4 Estimate Incentive Payment: $273,813</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: $1,314,323 | Year 3 Estimated Outcome Amount: $167,044 | Year 4 Estimated Outcome Amount: $273,813 | Year 5 Estimated Outcome Amount: $651,828 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5)*: $2,407,008
**Title of Outcome Measure (Improvement Target):** IT-13.1 Pain assessment (NQF-1637)

**Unique RHP outcome identification number:** 133355104.3.28/ Pass 3  
**Performing Provider/TPI:** Harris Health System/133355104

**Outcome Measure Description:**

IT-13.1 Pain assessment (NQF-1637) *(Non-standalone measure)*

Increase the percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.

Exclusion: patients with length of stay < 1 day in palliative care or patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

**Process Milestones:**

- DY2: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3: P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**

- DY 4: Increase by 3% the percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.
  Exclusion: patients with length of stay < 1 day in palliative care or patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

- DY 5: Increase by 5% the percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.
  Exclusion: patients with length of stay < 1 day in palliative care or patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

**Rationale:**

Research on care of patients with serious incurable illness and those nearing the end of life shows they experience high rates of pain (40-70% prevalence) and other physical, emotional, and spiritual causes of distress. Pain is under-recognized by clinicians and undertreated, resulting in excess suffering from patients with serious illness. Pain screening and assessments are necessary in order to improve the patient centered outcome of pain, and its effects on global outcomes of function and quality of life.

**Outcome Measure Validation:**

The goal of this project is to expand our Palliative Care Program with an increase in mid-level practitioners, physicians and social workers to provide palliative care to patients who would otherwise not have access. This model has been shown to prevent emergency center visits, as well as hospital and ICU admissions. The cost of care for seriously ill and dying patients is
frequently greater than the reimbursement for such care due to long length-of-stay and utilization of high-cost beds (ICU), drugs, and procedures, and the fixed payment design of reimbursement. Currently we provide this type of care to less than 350 persons a year. We intend to increase the patient population served to a total of 1,000 patients by the end of DY5. The research available regarding palliative care shows significant reductions in pharmacy, laboratory, and intensive care costs for care coordinated through a palliative program.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133355104.3.28</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>133355104.2.7</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>60 Patients a Year Currently</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 2 [P-2]:</strong> Establish baseline rates</td>
<td><strong>Outcome Improvement Target 1 [IT-13.1]:</strong> Pain assessment Improvement Target: Increase by 3% the percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. Data Source: EHR, palliative care database</td>
<td><strong>Outcome Improvement Target 2 [IT-13.1]:</strong> Pain assessment Improvement Target: Increase by 5% the percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. Data Source: EHR, palliative care database</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $1,289,426</td>
<td>Process Milestone 2 Estimated Incentive Payment: $140,552</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $222,193</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $528,942</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: $1,289,426 | Year 3 Estimated Outcome Amount: $140,552 | Year 4 Estimated Outcome Amount: $222,193 | Year 5 Estimated Outcome Amount: $528,942 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $2,181,113
**Title of Outcome Measure (Improvement Target):** IT-13.3 Proportion with more than one emergency room visit in the last days of life (NQF 0211)

**Unique RHP outcome identification number:** 133355104.3.29/ Pass 3

**Performing Provider/TPI:** Harris Health System/133355104

**Outcome Measure Description:**

IT-13.3 Proportion with more than one emergency room visit in the last days of life (NQF 0211)- Decrease the percentage of patients who died from cancer or another life-limiting illness with more than one emergency room visit in the last days of life. *(Standalone measure)*

**Process Milestones:**

- DY2: P- 2 Establish baseline rates
- DY3: P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

**Outcome Improvement Targets for each year:**

- DY4: IT-13.3 Decrease the percentage of patients who died from cancer or another life-limiting illness with more than one emergency room visit in the last days of life by 3%.
- DY5: IT-13.3 Decrease the percentage of patients who died from cancer or another life-limiting illness with more than one emergency room visit in the last days of life by 5%.

**Rationale:**

Generally, emergency centers are not organized to provide comfort and palliative care. Although, when operationalized as a claims-based measure, this does not take patient preferences into account, the idea is for the measure to be seen as an overall indication of practice style and/or available palliative resources. An individual patient experiencing this process of care has not necessarily received poor quality care, but unless there is a reason to think that the patients in one setting have a significantly greater proportion with differing preferences, aggregate rates of the measure can justifiably be compared across settings. In this way it is a reflection of the quality of end-of-life care.

**Outcome Measure Valuation:**

The goal of this project is to expand our Palliative Care Program with an increase in mid-level practitioners, physicians and social workers to provide palliative care to patients who would otherwise not have access. This model has been shown to prevent emergency center visits, as well as hospital and ICU admissions. The cost of care for seriously ill and dying patients is frequently greater than the reimbursement for such care due to long length-of-stay and utilization of high-cost beds (ICU), drugs, and procedures, and the fixed payment design of reimbursement. Currently we provide this type of care to less than 350 persons a year. We intend to increase the patient population served to a total of 1,000 patients by the end of DY5. The research available regarding palliative care shows significant reductions in pharmacy, laboratory, and intensive care costs for care coordinated through a palliative program.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>133355104.2.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong> [P-2]&lt;br&gt;Establish baseline rates&lt;br&gt;Data Source: EHR, palliative care database</td>
<td><strong>Process Milestone 2</strong> [P-4]&lt;br&gt;Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities&lt;br&gt;Data Source: EHR, palliative care database</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $1,289,426</td>
<td>Process Milestone 2 Estimated Incentive Payment: $140,552</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $1,289,426</td>
<td>Year 3 Estimated Outcome Amount: $140,552</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $2,181,113
**Title of Outcome Measure (Improvement Target):** IT-13.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213)

**Unique RHP outcome identification number:** 133355104.3.30/ Pass 3

**Performing Provider/TPI:** Harris Health System/133355104

**Outcome Measure Description:**

IT-13.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213) - Percentage of patients who died from cancer or other life-limiting illness admitted to the ICU in the last 30 days of life. *(Standalone measure)*

**Process Milestones:**

- DY2: P-2 Establish baseline rates
- DY3: P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

**Outcome Improvement Targets for each year:**

- DY4: IT-13.4 Decrease the percentage of patients who died from cancer or other life-limiting illness admitted to the ICU in the last 30 days of life by 3%.
- DY5: IT-13.4 Decrease the percentage of patients who died from cancer or other life-limiting illness admitted to the ICU in the last 30 days of life by 5%.

**Rationale:**

Using patient satisfaction with end-of-life care as a desired outcome, patient survey data reflect patients’ desires to die at home and to not be connected to machines at the end-of-life. ICU use near the end of life may indicate a lack of discussion about advance directives. ICU care is expensive and uncomfortable, and generally not appropriate for the dying patient.

**Outcome Measure Validation:**

The goal of this project is to expand our Palliative Care Program with an increase in mid-level practitioners, physicians and social workers to provide palliative care to patients who would otherwise not have access. This model has been shown to prevent emergency center visits, as well as hospital and ICU admissions. The cost of care for seriously ill and dying patients is frequently greater than the reimbursement for such care due to long length-of-stay and utilization of high-cost beds (ICU), drugs, and procedures, and the fixed payment design of reimbursement. Currently we provide this type of care to less than 350 persons a year. We intend to increase the patient population served to a total of 1,000 patients by the end of DY5. The research available regarding palliative care shows significant reductions in pharmacy, laboratory, and intensive care costs for care coordinated through a palliative program.
<table>
<thead>
<tr>
<th>133355104.3.30</th>
<th>IT-13.4</th>
<th>Proportion admitted to the ICU in the last 30 days of life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harris Health System</td>
<td>133355104.2.7</td>
<td>133355104</td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:**

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-2]</strong> Establish baseline rates</td>
<td><strong>Process Milestone 2 [P-4]</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td><strong>Outcome Improvement Target 1</strong> [IT-13.4]: Proportion admitted to the ICU in the last 30 days of life Improvement Target: Decrease the percentage of patients who died from cancer or other life-limiting illness admitted to the ICU in the last 30 days of life by 3%. Data Source: EHR, claims</td>
<td><strong>Outcome Improvement Target 2</strong> [IT-13.4]: Proportion admitted to the ICU in the last 30 days of life Improvement Target: Decrease the percentage of patients who died from cancer or other life-limiting illness admitted to the ICU in the last 30 days of life by 5%. Data Source: EHR, claims</td>
</tr>
<tr>
<td>Data Source: EHR, palliative care database</td>
<td>Data Source: EHR, palliative care database</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $222,193</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $528,942</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $1,289,426</td>
<td>Process Milestone 3 Estimated Incentive Payment: $140,552</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Year 2 Estimated Outcome Amount: $1,289,426</td>
<td>Year 3 Estimated Outcome Amount: $140,552</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Year 4 Estimated Outcome Amount: $222,193</td>
<td>Year 5 Estimated Outcome Amount: $528,942</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $ 2,181,113*
Title of Outcome Measure (Improvement Target): IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Non-standalone measure)

Unique RHP outcome identification number(s): 133355104.3.31/ Pass 3

Performing Provider name/TPI: Harris Health System/133355104

Outcome Measure Description:

Process Milestones:
- DY2:
  - P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2 Establish baseline number of children age 6-9 that have seen a dental provider within the Harris Health System and have a dental sealant on a permanent first molar tooth.

Improvement Milestones and Targets:
- DY4:
  - IT-7.1 Dental Sealant: Number of children age 6-9 with a dental sealant on a permanent first molar tooth.
  - Target: Increase by 20% of DY3 baseline.
- DY5:
  - IT-7.1 Dental Sealant: Number of children age 6-9 with a dental sealant on a permanent first molar tooth.
  - Target: Increase by 30% of DY3 baseline.

Rationale:
In DY2, we will focus on process milestone P-1 to allow Harris Health to plan for the implantation of pediatric dental clinics. In DY3, we will establish the baseline rate to be used for measuring and reporting purposes in DY4 and DY5. During DY4 and DY5, we will begin to measure improvement targets. Our goal is to increase the number of children age 6-9 with a dental sealant on a permanent first molar tooth by increasing access to dental care.

Outcome Measure Valuation:
The goal is to increase the number of children accessing dental services. Currently, Harris Health System only offers adult oral health care at some of our centers. Oral health services are essential in preventing gum disease and cavities, which have been linked to other diseases such as diabetes and heart stroke. Access to oral health services is especially important for children and adolescents, since dental problems may affect quality of life and ability to succeed. Children from lower-income families often do not receive timely treatment for tooth decay, and they are more likely to suffer from chronic conditions (National Center for...
Chronic Disease Prevention and Health Promotion). Sealants can provide protection from dental decay or cavities. Applying dental sealants is more cost effective than filling a cavity. By increasing the number of children with dental sealants, we are reducing the risks of cavities.
<table>
<thead>
<tr>
<th>Project #</th>
<th>Category</th>
<th>Description</th>
<th>Estimated Incentive Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>133355104.3.31</td>
<td>IT-7.1</td>
<td>Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth</td>
<td>$971,967</td>
</tr>
</tbody>
</table>

**Starting Point/Baseline:** TBD

**Year 2 (10/1/2012 – 9/30/2013):**
- **Process Milestone 1 [P-1]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - Data source: Planning Documentation
  - Process Milestone 1 Estimated Incentive Payment (*maximum amount*): $971,967

**Year 3 (10/1/2013 – 9/30/2014):**
- **Process Milestone 2 [P-2]:** Establish baseline number of children age 6-9 that have seen a dental provider within the Harris Health System and have a dental sealant on a permanent first molar tooth.
  - Data Source: EHR
  - Process Milestone 2 Estimated Incentive Payment: $246,076

**Year 4 (10/1/2014 – 9/30/2015):**
- **Outcome Improvement Target 1 [IT-7.1]:** Dental Sealant: Number of children age 6-9 with a dental sealant on a permanent first molar tooth.
  - Improvement Target: Increase by 20% of DY3 baseline.
  - Data Source: EHR
  - Outcome Improvement Target 1 Estimated Incentive Payment: $381,068

**Year 5 (10/1/2015 – 9/30/2016):**
- **Outcome Improvement Target 2 [IT-7.1]:** Dental Sealant: Number of children age 6-9 with a dental sealant on a permanent first molar tooth.
  - Improvement Target: Increase by 30% of DY3 baseline.
  - Data Source: EHR
  - Outcome Improvement Target 2 Estimated Incentive Payment: $907,154

**Year 2 Estimated Outcome Amount:** $971,967

**Year 3 Estimated Outcome Amount:** $246,076

**Year 4 Estimated Outcome Amount:** $381,068

**Year 5 Estimated Outcome Amount:** $907,154

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $2,506,265
**Title of Outcome Measure (Improvement Target):** IT-7.6 Urgent Dental Care Needs in Children: Percentage of children with urgent dental care needs (Standalone measure)

**Unique RHP outcome identification number(s):** 133355104.3.32/ Pass 3

**Performing Provider name/TPI:** Harris Health System/133355104

**Outcome Measure Description:**

**Process Milestones:**

- **DY2:**
  - P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- **DY3:**
  - P-2 Establish baseline rates of patients of record with urgent dental care needs within the Harris Health System pediatric dental clinics

**Improvement Milestones and Targets:**

- **DY4:**
  - IT-7.6 Urgent Dental Care Needs: Percentage of patients of record with urgent dental care needs. Target: Reduce by 5% of DY3 baseline

- **DY5:**
  - IT-7.6 Urgent Dental Care Needs: Percentage of patients of record with urgent dental care needs. Target: Reduce by 10% of DY3 baseline

**Rationale:**

In DY2, we will focus on process milestone P-1 to allow Harris Health to plan for the implantation of pediatric dental clinics. In DY3, we will establish the baseline rate to be used for measuring and reporting purposes in DY4 and DY5. During DY4 and DY5, we will begin to measure improvement targets. Our goal is to decrease the percentage of children of record seen within our pediatric dental clinics with urgent dental care needs by providing preventive dental treatments.

**Outcome Measure Valuation:**

The goal is to increase the number of children accessing dental services. Currently, Harris Health System only offers adult oral health care at some of our centers. Oral health services are essential in preventing gum disease and cavities, which have been linked to other diseases such as diabetes and heart stroke. Access to oral health services is especially important for children and adolescents, since dental problems may affect quality of life and ability to succeed. Children from lower-income families often do not receive timely treatment for tooth decay, and they are more likely to suffer from chronic conditions (National Center for...
Chronic Disease Prevention and Health Promotion). Treating cavities and other oral health problems at an early age has potential cost savings by preventing other chronic diseases that may come later in life. By providing preventative oral health services to children and adolescents, we hope to decrease the need of urgent dental care by 10% in DY5. This will also reduce cost of care, as urgent visits require more costly treatments and procedures.
### Urgent Dental Care Needs in Children: Percentage of children with urgent dental care needs

**Harris Health System**

**133355104.3.32**

| Related Category 1 or 2 Projects: | 133355104.1.17 |
| Starting Point/Baseline: | TBD |

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 2 [P-2]:</strong> Establish baseline rates of patients of record with urgent dental care needs within the Harris Health System pediatric dental clinics</td>
<td><strong>Outcome Improvement Target 1 [IT-7.6] U Urgent Dental Care Needs:</strong> Percentage of patients of record with urgent dental care needs. Improvement Target: Reduce by 5% of DY3 baseline</td>
<td><strong>Outcome Improvement Target 2 [IT-7.6] U Urgent Dental Care Needs:</strong> Percentage of patients of record with urgent dental care needs. Improvement Target: Reduce by 10% of DY3 baseline</td>
</tr>
<tr>
<td>Data source: Planning Documentation</td>
<td>Data Source: EHR</td>
<td>Data Source: EHR</td>
<td>Data Source: EHR</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment <em>maximum amount</em>: $971,967</td>
<td>Process Milestone 2 Estimated Incentive Payment: $246,076</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $381,068</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $907,154</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: $971,967 | Year 3 Estimated Outcome Amount: $246,076 | Year 4 Estimated Outcome Amount: $381,068 | Year 5 Estimated Outcome Amount: $907,154 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $2,506,265*
Matagorda Regional Medical Center
Pass 1
**Title of Outcome Measure (Improvement Target):** IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate

**Unique RHP outcome identification number(s):** 130959304.3.1

**Performing Provider Name/TPI:** Matagorda Regional Medical Center/130959304

**Outcome Measure Description:**
IT-2.11 will be defined as the number of acute care hospitalizations for ambulatory care sensitive conditions (grand mal status and other epileptic convulsions, chronic pulmonary diseases (COPD), asthma, heart failure and, pulmonary edema, hypertension, angina and diabetes) for patients in defined population 75 years of age and under.

**Process Milestones:**
- DY2: P-1; P-2; P-3
- DY3: P-2; P-3; P-4
- DY4: P-4; P-5
- DY5: P-4; P-5

**Outcome Improvement Target(s) for each year:**
- **DY4:**
  - IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate
  - Reduce admission rate for acute care hospitalizations for ambulatory care sensitive conditions for individuals under 75 years of age by 5% from DY2 base for those patients of the chronic disease specialty clinic.

- **DY5:**
  - IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate
  - Reduce admission rate for acute care hospitalizations for ambulatory care sensitive conditions for individuals under 75 years of age by 10% from DY2 base for those patients of the chronic clinic.

**Rationale:**
The analysis of admissions into the system for acute chronic conditions, the prevalence of chronic disease in the specified population, as well as the rate of uncontrolled chronic conditions is the baseline for the establishment of a chronic disease specialty clinic. To establish chronic clinic, key process milestones of project planning (P-1), confirmation of disease rates, admission rates and subsequently the measurement of the performance of the chronic clinic (P-2)(P-3) will be accomplished. Process Milestones P-1, P-2, P-3 will all be completed in years 2 and 3. Beginning in year 3 and continuing through year 5, Plan Do Study Act (PDSA) cycles (P-4) will be utilized for process improvement and refinement. The lessons learned and best practices will be shared across Region 3 (P-5) as they are experienced.

Although slight improvement in controlling chronic diseases as well as reducing Ambulatory Care Sensitive Conditions Admissions is expected in Year 3, improvements
in this health disparity is expected to be measurable in years 4 and 5. The original study documented a 30% reduction in admissions rate over a 6 year period\(^1\) and supports the expectation of a 5% and 10% in DY4 and 5 respectively.

**Outcome Measure Valuation:**
The direct dollar association with achieving the outcomes of this project is mainly in the arena of cost avoidance. For each acute admission reduction for disease related issues, we estimate a savings of approximately $15,000 - $20,000 including the associated reduction in disease crises oriented emergency department visits. Therefore, by reducing 1 admission on 50% of the active clinic patients described as a process milestone, it is possible to avoid as much as $1,000,000 of unnecessary hospital related costs.

\(^1\) http://www.qualitymeasures.ahrq.gov/content.aspx?id=27275
### Related Category 1 or 2 Projects:

**Matagorda Regional Medical Center**

**Ambulatory Care Sensitive Conditions Admissions Rate**

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>DY2 Ambulatory Admissions Rate - Diabetes, Hypertension, COPD, Asthma</th>
</tr>
</thead>
</table>
| **Year 2**<br>(10/1/2012 – 9/30/2013) | **Process Milestone 1** [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
**Data Source:** Reports, Minutes |
| **Process Milestone 2** [P-2]: Establish baseline rates for admissions targeted and for chronic conditions prior to chronic clinic establishment – base year 10/1/12 through 9/30/13  
**Data Source:** EHR, state and national reports |
| **Process Milestone 3** [P-3]: Develop and test data systems to establish performance targets for providers, targeted clinical improvement and reduced admissions  
**Data Source:** HER, HIET |
| **Year 3**<br>(10/1/2013 – 9/30/2014) | **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Data Source:** Internal Reports |
| **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders  
**Data Source:** EHR, Business Intelligence, reports |
| **Process Milestone 6** Estimated Incentive Payment: $71,330 |
| **Year 4**<br>(10/1/2014 – 9/30/2015) | **Outcome Improvement Target 1** [IT-1.1]: Ambulatory Care Sensitive Conditions Admissions Rate  
**Improvement Target:** Reduce admission rate for acute care hospitalizations for ambulatory care sensitive conditions for individuals under 75 years of age by 5% from 2013 base for those patients of the chronic clinic  
**Data Source:** HER, State, National Reports |
| **Process Milestone 6** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Data Source:** Internal Reports |
| **Process Milestone 5** Estimated Incentive Payment: $71,329 |
| **Year 5**<br>(10/1/2015 – 9/30/2016) | **Outcome Improvement Target 2** [IT-1.1]: Ambulatory Care Sensitive Conditions Admissions Rate  
**Improvement Target:** Reduce admission rate for acute care hospitalizations for ambulatory care sensitive conditions for individuals under 75 years of age by 10% from 2013 base for those patients of the chronic clinic  
**Data Source:** HER, State National Reports |
| **Process Milestone 8** [P-3]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Data Source:** Internal Reports |
| **Process Milestone 7** [P-5]: Disseminate findings, including lessons learned and best practices, to |

---

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $41,025

**Process Milestone 2 Estimated Incentive Payment:** $41,025

**Process Milestone 3 Estimated Incentive Payment:** $41,025

**Process Milestone 4 Estimated Incentive Payment:** $71,329

**Process Milestone 5 Estimated Incentive Payment:** $71,330

**Process Milestone 6 Estimated Incentive Payment:** $76,306

**Process Milestone 7 Estimated Incentive Payment:** $76,306

**Process Milestone 8 Estimated Incentive Payment:** $182,472

**Process Milestone 9 Estimated Incentive Payment:** $182,472

**Outcome Improvement Target 1 Estimated Incentive Payment:** $76,306

**Outcome Improvement Target 2 Estimated Incentive Payment:** $182,471
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>DY2 Ambulatory Admissions Rate - Diabetes, Hypertension, COPD, Asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>Process Milestone 3</strong> Estimated Incentive Payment: $41,024</td>
</tr>
<tr>
<td></td>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
</tr>
<tr>
<td></td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td></td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td></td>
<td>Stakeholders Data Source: EHR, Business Intelligence, reports</td>
</tr>
<tr>
<td></td>
<td><strong>Process Milestone 7</strong> Estimated Incentive Payment: $76,306</td>
</tr>
<tr>
<td></td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td></td>
<td>Stakeholders Data Source: EHR, Business Intelligence, reports</td>
</tr>
<tr>
<td></td>
<td><strong>Process Milestone 9</strong> Estimated Incentive Payment: $182,471</td>
</tr>
<tr>
<td></td>
<td><strong>Year 2 Estimated Outcome Amount:</strong></td>
</tr>
<tr>
<td></td>
<td>Year 3 Estimated Outcome Amount: $142,659</td>
</tr>
<tr>
<td></td>
<td>Year 4 Estimated Outcome Amount: $228,918</td>
</tr>
<tr>
<td></td>
<td>Year 5 Estimated Outcome Amount: $547,414</td>
</tr>
<tr>
<td></td>
<td>(add incentive payments amounts from each milestone/outcome</td>
</tr>
<tr>
<td></td>
<td>improvement target): $123,074</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong></td>
<td><em>(add outcome amounts over DYs 2-5): $1,042,065</em></td>
</tr>
</tbody>
</table>
Matagorda Regional Medical Center
Pass 2
Title of Outcome Measure (Improvement Target): IT – 9.2 ED appropriate utilization

Unique RHP outcome identification number(s): 130959304 3.2/Pass 2
Performing Provider Name/TPI: Matagorda Regional Medical Center/130959304

Outcome Measure Description:
- Reduce all ED visits (including ACSC)\(^1\)
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)\(^2\)
- Reduce Emergency Department visits for target conditions
  - Congestive Heart Failure
  - Diabetes
  - End Stage Renal Disease
  - Cardiovascular Disease /Hypertension
  - Behavioral Health/Substance Abuse
  - Chronic Obstructive Pulmonary Disease
  - Asthma

Process Milestones:
- DY2: P-1; P-2; P-3
- DY3: P-2; P-3; P-4
- DY4: P-4; P-5
- DY5: P-4; P-5

Outcome Improvement Target(s) for each year:
- **DY4:**
  - IT-9.2 ED appropriate utilization
    - Reduce all ED visits (including ACSC)\(^3\)
    - Reduce pediatric Emergency Department visits (CHIPRA Core Measure)\(^4\)
    - Reduce Emergency Department visits for target conditions
      - Congestive Heart Failure
      - Diabetes
      - End Stage Renal Disease
      - Cardiovascular Disease /Hypertension
      - Behavioral Health/Substance Abuse
      - Chronic Obstructive Pulmonary Disease
      - Asthma

- **DY5:**
  - IT-9.2 ED appropriate utilization

\(^1\)http://archive.ahrq.gov/data/safetynet/billappb.htm
\(^3\)http://archive.ahrq.gov/data/safetynet/billappb.htm
• Reduce all ED visits (including ACSC)\(^5\)
• Reduce pediatric Emergency Department visits (CHIPRA Core Measure)\(^6\)
• Reduce Emergency Department visits for target conditions
  ▪ Congestive Heart Failure
  ▪ Diabetes
  ▪ End Stage Renal Disease
  ▪ Cardiovascular Disease /Hypertension
  ▪ Behavioral Health/Substance Abuse
  ▪ Chronic Obstructive Pulmonary Disease
  ▪ Asthma

**Rationale:**
The analysis of visits to the hospital emergency department led to the rationale for establishing a patient care navigation program to reduce unnecessary utilization of one of the more expense pieces of the health care continuum. To establish the patient care navigation program we chose key process milestones of project planning, confirmation of utilization statistics, patient needs and available community resources. Process Milestones will all be completed in years 2 and 3. Beginning in year 3 and continuing through year 5, Plan Do Study Act (PDSA) cycles will be utilized for process improvement and refinement. The lessons learned and best practices will be shared across Region 3 as they are experienced to allow for improvement and/or intervention as needed.

**Outcome Measure Valuation:**
Matagorda Regional Medical Center has approximately 20,000 visits to the Emergency Department annually. Records reflect a potential of 40 – 50%\(^7\) of the visits could have been treated in another venue. If the Patient Care Navigator Program is successful at reducing unnecessary ED visits by a conservative 10%, a savings of as much as $2,000,000\(^8\) could be realized by the end of the project period (as compared to a standard physician office visit).

\(^5\)http://archive.ahrq.gov/data/safetynet/billappb.htm
\(^7\)MCHD ED Records 2012
\(^8\)Cost of an average ED visit compared to an office visit. *Consumer Health Ratings, 2011*
## ED Appropriate Utilization

### Related Category 1 or 2 Projects:

<table>
<thead>
<tr>
<th>Projects</th>
<th>2.1</th>
</tr>
</thead>
</table>

### Starting Point/Baseline:

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1 [P-1]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- Data Source: Reports, Minutes

**Process Milestone 4 [P-4]:**
- Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
- Data Source: Internal Reports

**Process Milestone 4 Estimated Incentive Payment:** $11,293

**Process Milestone 5 [P-5]:**
- Disseminate findings, including lessons learned

### Outcome Improvement Target 1

- IT-9.2 ED appropriate utilization
  - Reduce all ED visits (including ACSC)\(^9\)
  - Reduce pediatric Emergency Department visits (CHIPRA Core Measure)\(^10\)
  - Reduce Emergency Department visits for target conditions
  - Congestive Heart Failure
  - Diabetes

### Outcome Improvement Target 2

- IT-9.2 ED appropriate utilization
  - Reduce all ED visits (including ACSC)\(^11\)
  - Reduce pediatric Emergency Department visits (CHIPRA Core Measure)\(^12\)
  - Reduce Emergency Department visits for target conditions
  - Congestive Heart Failure
  - Diabetes
  - End Stage Renal Disease
  - Cardiovascular Disease /Hypertension
  - Behavioral Health/Substance Abuse
  - Chronic Obstructive Pulmonary Disease
  - Asthma

---

\(^9\)http://archive.ahrq.gov/data/safetynet/billappb.htm


\(^11\)http://archive.ahrq.gov/data/safetynet/billappb.htm

\(^12\)http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>2.1 ED Appropriate Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Matagorda Regional Medical Center</td>
</tr>
<tr>
<td>DY2 Unnecessary visits to the ED</td>
<td>130959304</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
</tr>
<tr>
<td>(10/1/2012 – 9/30/2013)</td>
<td>(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Year 4</td>
<td>Year 5</td>
</tr>
<tr>
<td>(10/1/2014 – 9/30/2015)</td>
<td>(10/1/2015 – 9/30/2016)</td>
</tr>
</tbody>
</table>

**Process Milestone 2 [P-2]:** Establish baseline rates for admissions targeted and for chronic conditions prior to chronic clinic establishment – base year 10/1/12 through 9/30/13.

- Data Source: EHR, state and national reports

**Process Milestone 3 [P-3]:** Develop and test data systems to establish performance targets for providers, targeted clinical improvement and reduced admissions.

- Data Source: EHR, Business Intelligence, reports

**Process Milestone 5 Estimated Incentive Payment:** $11,294

- End Stage Renal Disease
- Cardiovascular Disease/Hypertension
- Behavioral Health/Substance Abuse
- Chronic Obstructive Pulmonary Disease
- Asthma

- Data Source: ED and navigation program records

**Outcome Improvement Target 1 Estimated Incentive Payment:** $12,221

**Process Milestone 6 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

- Data Source: Internal Reports

**Process Milestone 8 Estimated Incentive Payment:** $29,121

**Process Milestone 8 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

- Data Source: Internal Reports

**Process Milestone 9 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders.

- Data Source: EHR, Business Intelligence, reports
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>DY2 Unnecessary visits to the ED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>2.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source:</td>
<td>EHR, HIET</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3</td>
<td>Estimated Incentive Payment: $6,356</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 6</td>
<td>Estimated Incentive Payment: $12,221</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 7 [P-5]</td>
<td>Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>Data Source: EHR, Business Intelligence, reports</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 7</td>
<td>Estimated Incentive Payment: $12,222</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):</td>
<td>$19,067</td>
<td>Year 3 Estimated Outcome Amount: $22,587</td>
<td>Year 4 Estimated Outcome Amount: $36,664</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</td>
<td>(add outcome amounts over DYs 2-5): $165,682</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Matagorda Regional Medical Center
Pass 3
Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization

Unique RHP outcome identification number(s):
Performing Provider Name/TPI: Matagorda Regional Medical Center/130959304

Outcome Measure Description:

- Reduce all ED visits (including ACSC)\(^1\)
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)\(^2\)
- Reduce Emergency Department visits for target conditions
  - Congestive Heart Failure
  - Diabetes
  - End Stage Renal Disease
  - Cardiovascular Disease /Hypertension
  - Behavioral Health/Substance Abuse
  - Chronic Obstructive Pulmonary Disease
  - Asthma

Process Milestones:
- DY2: P-1; P-2; P-3
- DY3: P-2; P-3; P-4
- DY4: P-4; P-5
- DY5: P-4; P-5

Outcome Improvement Target(s) for each year:
- DY4:
  - IT-9.2  ED appropriate utilization
    - Reduce all ED visits (including ACSC)\(^3\)
    - Reduce pediatric Emergency Department visits (CHIPRA Core Measure)\(^4\)
    - Reduce Emergency Department visits for target conditions
      - Congestive Heart Failure
      - Diabetes
      - End Stage Renal Disease
      - Cardiovascular Disease /Hypertension
      - Behavioral Health/Substance Abuse
      - Chronic Obstructive Pulmonary Disease
      - Asthma

\(^1\)http://archive.ahrq.gov/data/safetynet/billappb.htm
\(^3\)http://archive.ahrq.gov/data/safetynet/billappb.htm
• **DY5:**
  - IT-9.2 ED appropriate utilization
    - Reduce all ED visits (including ACSC)\(^5\)
    - Reduce pediatric Emergency Department visits (CHIPRA Core Measure)\(^6\)
    - Reduce Emergency Department visits for target conditions
      - Congestive Heart Failure
      - Diabetes
      - End Stage Renal Disease
      - Cardiovascular Disease /Hypertension
      - Behavioral Health/Substance Abuse
      - Chronic Obstructive Pulmonary Disease
      - Asthma

**Rationale:**
The analysis of visits to the hospital emergency department indicates unnecessary utilization of one of the most expensive pieces of the health care continuum, the ED. To provide an alternative to care at the right time and right setting primary and urgent care services will be expanded to evenings and weekends. A nurse advice call line manned with RN professionals trained in pediatric as well as adult triage will promote the use of the expanded primary and urgent care services. Key process milestones of project planning, identification of capacity utilization statistics from inception to Year 3, identification of patient needs, matching patient needs to resources and testing data systems and processes will be evaluated and completed in years 2 and 3. Beginning in year 3 and continuing through year 5, Plan Do Study Act (PDSA) cycles will be utilized for process improvement and refinement. The lessons learned and best practices will be shared across Region 3 as they are experienced to allow for improvement and/or intervention as needed.

**Outcome Measure Valuation:**
Matagorda Regional Medical Center has approximately 20,000 visits to the Emergency Department annually. Records reflect a potential of 40 – 50%\(^7\) of the visits could have been treated in another venue. If the expanded primary care and urgent care and the nurse advise line is successful at reducing unnecessary ED visits by a conservative 15%, a savings of as much as $3,000,000\(^8\) could be realized by the end of the project period (as compared to a standard physician office visit).

\(^5\) [http://archive.ahrq.gov/data/safetynet/billappb.htm](http://archive.ahrq.gov/data/safetynet/billappb.htm)
\(^7\) MCHD ED Records 2012
\(^8\) Cost of an average ED visit compared to an office visit. *Consumer Health Ratings, 2011*
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>1.3 Expand Existing primary care capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Matagorda Regional Medical Center</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Starting Point/Baseline:**
- DY2 Unnecessary visits to the ED

**Projects:**
1. **Process Milestone 1 [P-1]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
   - Data Source: Reports, Minutes
   - Process Milestone 1 Estimated Incentive Payment (maximum amount): $20,305

2. **Process Milestone 4[P-3]:** Evaluate rates for unnecessary ER visits and utilization rates of nurse advice line and expanded primary and urgent care visits - year 3 10/1/2013/9/30/2014
   - Data Source: EHR, state and national reports
   - Process Milestone 4 Estimated Incentive Payment: $18,249

3. **Outcome Improvement Target 1 (IT 1.6.1):**
   - IT-9.2 ED appropriate utilization
     - Reduce all ED visits (including ACSC)11
     - Reduce pediatric Emergency Department visits (CHIPRA Core Measure)12
     - Reduce Emergency Department visits for target conditions
       - Congestive Heart Failure
       - Diabetes
     - End Stage Renal Disease
     - Cardiovascular Disease /Hypertension
     - Behavioral Health/Substance Abuse
     - Chronic Obstructive Pulmonary Disease

4. **Outcome Improvement Target 2 [IT-1.6.1]:**
   - IT-9.2 ED appropriate utilization
   - Reduce all ED visits (including ACSC)11
   - Reduce pediatric Emergency Department visits (CHIPRA Core Measure)12
   - Reduce Emergency Department visits for target conditions
   - Congestive Heart Failure
   - Diabetes
   - End Stage Renal Disease
   - Cardiovascular Disease /Hypertension
   - Behavioral Health/Substance Abuse
   - Chronic Obstructive Pulmonary Disease

### Related Category 1 or 2 Projects: ED appropriate utilization

| Matagorda Regional Medical Center | 130959304 |

#### Starting Point/Baseline:

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 2 [P-2]:** Establish baseline rates for unnecessary ER visits and utilization rates of nurse advise line and expanded primary care and urgent care – base year 10/1/2012-9/30/2013  
Data Source: EHR, state and national reports

- **Process Milestone 2 Estimated Incentive Payment:** $20,306
- **Process Milestone 5 Estimated Incentive Payment:** $18,249

**Process Milestone 6 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
Data Source: Internal Reports

- **Process Milestone 6 Estimated Incentive Payment:** $18,249

**Process Milestone 7 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders  
Data Source: Internal Reports

- **Process Milestone 8 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
Data Source: Internal Reports

- **Outcome Improvement Target 1 Estimated Incentive Payment:** $39,885

- **Process Milestone 10 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
Data Source: Internal Reports

- **Process Milestone 8 Estimated Incentive Payment:** $94,948

- **Process Milestone 11 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders  
Data Source: EHR, Business Intelligence, reports

- **Process Milestone 9 Estimated Incentive Payment:** $94,948

#### Outcome Improvement Target 2 Estimated Incentive Payment: $94,948

- **Process Milestone 10 [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities**
  - Data Source: Internal Reports

- **Process Milestone 8 Estimated Incentive Payment:** $94,948

- **Process Milestone 11 [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders**
  - Data Source: EHR, Business Intelligence, reports

- **Process Milestone 9 Estimated Incentive Payment:** $94,948
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>1.3 Expand Existing primary care capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>DY2 Unnecessary visits to the ED</td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>targets for providers based on patient needs&lt;br&gt;Data Source: EHR, HIET</td>
<td>Data Source: EHR, Business Intelligence, reports</td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $20,306</td>
<td><strong>Process 7</strong> Estimated Incentive Payment: $18,249</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong>&lt;br&gt;(add outcome amounts over DYs 2-5): $538,412</td>
<td></td>
</tr>
</tbody>
</table>
Memorial Hermann Hospital

Pass 1
**Title of Outcome Measure (Improvement Target):** IT-1.10 Diabetes care: HBA1c poor control (>9.0%)

**Performing Provider:** Memorial Hermann Hospital/TPI 137805107

**Unique RHP outcome identification number(s):** 137805107.3.1

**Outcome Measure Description:**
To achieve improvement under this metric, Memorial Hermann will engage in project planning during DY 2. In DY 3, Memorial Hermann will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Memorial Hermann intends to improve the management of the diabetes population by 3% on the HBA1c scale. In DY 5, Memorial Hermann intends to improve the management of the diabetes population by 5% on the HBA1c scale.

**Process Milestones:**
- **DY2:**
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- **DY3:**
  - P-2: Establish baseline rates

**Outcome Improvement Targets for each year:**
- **DY4:**
  - IT-1.10 Increase % of patients with A1c <9% over baseline by 3%
- **DY5:**
  - IT-1.10 Increase % of patients with A1c <9% over baseline by 5%

**Rationale:**
The greater Houston area faces several major healthcare challenges, including a lack of primary care capacity, which results in poor management of chronic conditions that are prevalent in the population like diabetes. This challenge will be addressed by Memorial’s Network Development project (137805107.1.1), and In the Agency for Healthcare Research and Quality’s 2011 report, Texas ranks last in the nation on health care quality. In the same report, Texas scored particularly weak on diabetes care. Process milestones 1 & 2 were chosen to take our current patient population and calculate a baseline rate of % of patients with diabetes that have an A1C <9%.

This is a relevant outcome measure for project 1.1.1 for physician network development because by adding incremental primary care providers, we will care for more of our RHP patient population and yet have a mechanism in place to monitor and improve their diabetes control through focused follow up care by our primary care physicians. Improvement target is the measure itself and we want to grow the % < 9% which indicates the patient’s diabetes is in control.

**Outcome Measure Valuation:**
The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of
patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

Focus on successful management resulting in reduced # of patients with A1c > 9 improves the patient health status, reduces costs and avoids admissions, thus creating greater access for the RHP 3 underserved patient population.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>137805107.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td>137805107.3.1</td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans.</td>
<td><strong>Process Milestone 2</strong> [P-2]: Establish baseline rates. &lt;br&gt;<strong>Data Source:</strong> Analysis of patient records.</td>
</tr>
<tr>
<td>Data Source: Documentation of project planning.</td>
<td>Process Milestone 3 Estimated Incentive Payment: $575,453</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $496,453</td>
<td><strong>Outcome Improvement Target 1</strong> Improvement Target: Calculate % of patients with A1c &lt; 9% with a 3% improvement over baseline as goal. &lt;br&gt;<strong>Data Source:</strong> Patient Records.</td>
</tr>
<tr>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td>Year 3 Estimated Outcome Amount: $575,453</td>
</tr>
<tr>
<td><strong>Process Milestone 3</strong>&lt;br&gt;Estimated Incentive Payment: $575,453</td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong> $923,402</td>
</tr>
<tr>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $923,402</td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1</strong> Improvement Target: Calculate % of patients with A1c &lt; 9% with a 3% improvement over baseline as goal.</td>
<td><strong>Outcome Improvement Target 2</strong> Improvement Target: Calculate % of patients with A1c &lt; 9% with a 3% improvement over baseline as goal. &lt;br&gt;<strong>Data Source:</strong> Patient Records.</td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount: $2,208,134</td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong> $2,208,134</td>
</tr>
<tr>
<td><strong>Year 5</strong>&lt;br&gt;(10/1/2015 – 9/30/2016)</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $4,203,442</td>
</tr>
</tbody>
</table>
**Title of Outcome Measure (Improvement Target):** IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate

**Performing Provider:** Memorial Hermann Hospital/TPI 137805107

**Unique RHP outcome identification number(s):** 137805107.3.2

**Outcome Measure Description:**
To achieve improvement under this metric, Memorial will engage in project planning during DY 2. In DY 3, Memorial will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Memorial intends to reduce its Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate by at least 5% over the baseline recorded in DY 3. In DY 5, Memorial intends to improve its BH/SA 30-day readmission rate by at least 10% over baseline measurement.

**Process Milestones:**
- **DY2:**
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- **DY3:**
  - P-2: Establish baseline rates

**Outcome Improvement Targets for each year:**
- **DY4:**
  - IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate—5% reduction over DY3
- **DY5:**
  - IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate—10% reduction over baseline measurement

**Rationale:**
Mental health patients in the greater Houston area, particularly uninsured patients, face significant challenges in obtaining the mental health care services they need, which can result in negative utilization patterns including unnecessary inpatient admissions. These challenges will be addressed by Memorial’s Health Crisis Clinic project (137805107.1.2), which will result in greater access to emergency mental health care appointments for these underserved patients. Memorial Hermann expects to see an improvement in the Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate as a result of the associated Category 1 project.

**Outcome Measure Valuation:**
The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>137805107.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1</td>
<td></td>
</tr>
<tr>
<td>[P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans.</td>
<td></td>
</tr>
<tr>
<td>Data Source: Documentation of project planning.</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $472,585</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $472,585</td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2</td>
<td></td>
</tr>
<tr>
<td>[P-2]: Establish baseline rates.</td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR; claims.</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $547,787</td>
<td></td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount: $547,787</td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 1</td>
<td></td>
</tr>
<tr>
<td>[IT-3.8]: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate.</td>
<td></td>
</tr>
<tr>
<td>Improvement Target: 5% improvement over DY3.</td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR; claims.</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $879,007</td>
<td></td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount: $879,007</td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 2</td>
<td></td>
</tr>
<tr>
<td>[IT-3.8]: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate.</td>
<td></td>
</tr>
<tr>
<td>Improvement Target: 10% improvement over baseline</td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR; claims.</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $2,101,974</td>
<td></td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount: $2,101,974</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong></td>
<td>$4,001,353</td>
</tr>
</tbody>
</table>
**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease Management

**Performing Provider:** Memorial Hermann Hospital/TPI 137805107

**Unique RHP outcome identification number(s):** 137805107.3.3

**Outcome Measure Description:**
IT-1.1 Third next available appointment (Non-standalone measure)
Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient, or return visit/exam. The goals will be to decrease number of days to third next available appointment to two days for Specialty Care.

**Process Milestones:**
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
DY4:
IT-1.1 Reduce by 1 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days.

DY5:
IT-1.1 Reduce by 2 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to one day.

**Rationale:**
Access to care services can have an impact on healthcare outcomes, by providing early screening and treatment, patients are more likely to get these services when they are able to get appointments when first needed that accommodates their schedule. Since the goal of the project is to increase access to care and the third next available appointment is the healthcare industry's standard measure of access to care, we have chosen this outcome measure.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Process Milestone 2 [P-2]: Establish baseline rates for number of children with an asthma diagnosis and initial scores on the ATAQ</th>
<th>Outcome Improvement Target 1 [IT-1.1]: Reduce by 1 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care.</th>
<th>Outcome Improvement Target 2 [IT-1.1]: Reduce by 2 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: Appointment management system</td>
<td>Data Source: Appointment management system</td>
</tr>
<tr>
<td>Year 2 Estimated Incentive Payment: $ 182,910</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 105,978</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 339,183</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 803,067</td>
</tr>
<tr>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
<td>Process Milestone 3 Estimated Incentive Payment: $ 105,977</td>
<td>Year 3 Estimated Outcome Amount: $ 211,955</td>
<td>Year 4 Estimated Outcome Amount: $ 339,183</td>
</tr>
<tr>
<td>Data Source: Project reports, EMR, claims</td>
<td></td>
<td>Year 5 Estimated Outcome Amount: $ 803,067</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 182,910</td>
<td>Year 3 Estimated Outcome Amount: $ 211,955</td>
<td>Year 4 Estimated Outcome Amount: $ 339,183</td>
<td>Year 5 Estimated Outcome Amount: $ 803,067</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 1,537,115
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Performing Provider Name/TPI: Memorial Hermann Hospital/137805107

Unique RHP outcome identification number(s): 137805107.3.4

Outcome Measure Description:
IT-1.20 Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Standalone)
Increase the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months as measured by the Asthma Therapy Assessment Questionnaire (ATAQ). The ATAQ was found to have “good internal consistency and strong relationships with existing validated measures of childhood health status, asthma impact, and health care utilization.” The score range on the 7-item ATAQ is 0-7, with 0 showing complete control and each score of 1 thereafter indicating an area in need of improved management. The ATAQ will be administered at each patient visit for patients with a diagnosis of asthma. Improvement is defined as a downward trend in the total score of the 7-items on the ATAQ for each individual patient.

Process Milestones:
DY2:
P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-2: Establish baseline rates
P-3: Develop and test data systems

Outcome Improvement Targets for each year:
DY4:
IT-1.20: Increase by 3% over baseline the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months.
DY5:
IT-1.20: Increase by 5% over baseline the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months.

4 Ibid.
**Rationale:**

Asthma is one of the most common chronic illnesses among children in the U.S.\(^5\) The National Health Interview Survey (2011) found that 14% of all children living in the U.S., 21% of non-Hispanic black children, and 18% of children in poor families had ever been diagnosed with asthma.\(^6\) The number of children residing in the defined service area for this clinic is estimated at over 35,000, with 35% of those being non-Hispanic black (over 12,250) and 49% living below the federal poverty level (over 15,000). (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties.)

By extrapolating the U.S. statistics on children with asthma to the service area for this clinic, we can conservatively estimate that there are at least 2,700 children in this area suffering from asthma. Since the service area for this clinic has a high proportion of children living below the federal poverty level and a high proportion of non-Hispanic black children, achieving better asthma control for these patients will be an important and worthy outcome measure of increasing access to primary care services.

After the assessment of severity for the initial diagnosis, the goal then becomes asthma control, demonstrated through symptom manifestation and disease activity. The use of the ATAQ itself has benefits beyond simple measurement—it is a tool to ensure regular assessment and the consistent questioning can teach children and/or their parents which symptoms and experiences should be anticipated for managing their asthma.\(^7\)

**Outcome Measure Valuation:**

The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

---


\(^7\) Barbara P. Yawn, Susan K. Brenneman, Felicia C. Allen-Ramey, Michael D. Cabana and Leona E. Markson. Assessment of Asthma Severity and Asthma Control in Children. Pediatrics 2006;118;322
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates for number of children with an asthma diagnosis and initial scores on the ATAQ</td>
<td>Outcome Improvement Target 1 [IT-1.20] Increase by 3% over baseline the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months.</td>
<td>Outcome Improvement Target 2 [IT-1.20] Increase by 5% over baseline the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months.</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 105,978</td>
<td>Data Source: ATAQ, EHR</td>
<td>Data Source: ATAQ, EHR</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $182,910</td>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $339,183</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $803,067</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $182,910</td>
<td>Year 3 Estimated Outcome Amount: $211,956</td>
<td>Year 4 Estimated Outcome Amount: $339,183</td>
<td>Year 2 Estimated Outcome Amount: $803,067</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,537,115
**Title of Outcome Measure (Improvement Target):** OD-9 Right Care, Right Setting

**Performing Provider:** Memorial Hermann Hospital/TPI 137805107

**Unique RHP outcome identification number(s):** 137805107.3.5

**Outcome Measure Description:**
IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits (Standalone measure)
Numerator: Percentage of clinic patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period. Denominator: Denominator is all clinic patients age two through age 18, diagnosed with asthma during the measurement period. The denominator will include recipients with claims with asthma as primary or secondary diagnoses with the dates of service being within the measurement period.

**Process Milestones:**
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
DY4:
IT-9.3 Reduce by 3% the percentage of Emergency Department (ED) visits for asthma in the target population.
DY5:
IT-9.3 Reduce by 5% the percentage of Emergency Department visits for asthma in the target population.

**Rationale:**
Asthma is one of the most common chronic illnesses among children in the U.S.\(^8\) Access to primary care services will have an impact on healthcare outcomes by providing early screening and treatment. The goal of the project is to increase access to primary care, thereby making sure patients get the right care at the right setting at the right time. Appropriate primary care has the potential to prevent the acute worsening of the chronic illnesses such as asthma, thereby decreasing the need for emergency care. Hence ED visits for asthma will be a good outcome measure for this project.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the

---

amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>137805107.1.3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>To be determined during DY3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $182,910</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $105,978</td>
<td>Outcome Improvement Target 1 [IT-9.3]: Reduce by 3% the percentage of Emergency Department visits for asthma in the target population. Data Source: EMR, Claims Outcome Improvement Target 1 Estimated Incentive Payment: $339,182</td>
<td>Outcome Improvement Target 2 [IT-9.3]: Reduce by 5% the percentage of Emergency Department visits for asthma in the target population. Data Source: EMR, Claims Outcome Improvement Target 2 Estimated Incentive Payment: $803,066</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $182,910</td>
<td>Year 3 Estimated Outcome Amount: $211,955</td>
<td>Year 4 Estimated Outcome Amount: $339,182</td>
<td>Year 5 Estimated Outcome Amount: $803,066</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,537,114
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Performing Provider Name/TPI: Memorial Hermann Hospital/137805107

Unique RHP outcome identification number(s): 137805107.3.6

Outcome Measure Description:
IT-1.20 Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Standalone)
Increase the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months as measured by the Asthma Therapy Assessment Questionnaire (ATAQ). The ATAQ was found to have “good internal consistency and strong relationships with existing validated measures of childhood health status, asthma impact, and health care utilization.” The score range on the 7-item ATAQ is 0-7, with 0 showing complete control and each score of 1 thereafter indicating an area in need of improved management. The ATAQ will be administered at each patient visit for patients with a diagnosis of asthma. Improvement is defined as a downward trend in the total score of the 7-items on the ATAQ for each individual patient.

Process Milestones:
DY2:
P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-2: Establish baseline rates
P-3: Develop and test data systems

Outcome Improvement Targets for each year:
DY4:
IT-1.20: Increase by 3% over baseline the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months.
DY5:

12 Ibid.
IT-1.20: Increase by 5% over baseline the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months.

**Rationale:**
Asthma is one of the most common chronic illnesses among children in the U.S. The National Health Interview Survey (2011) found that 14% of all children living in the U.S., 21% of non-Hispanic black children, and 18% of children in poor families had ever been diagnosed with asthma. The number of children residing in the defined service area for this clinic is estimated at over 35,000, with 35% of those being non-Hispanic black (over 12,250) and 49% living below the federal poverty level (over 15,000). (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties.) By extrapolating the U.S. statistics on children with asthma to the service area for this clinic, we can conservatively estimate that there are at least 2,700 children in this area suffering from asthma. Since the service area for this clinic has a high proportion of children living below the federal poverty level and a high proportion of non-Hispanic black children, achieving better asthma control for these patients will be an important and worthy outcome measure of increasing access to primary care services.

After the assessment of severity for the initial diagnosis, the goal then becomes asthma control, demonstrated through symptom manifestation and disease activity. The use of the ATAQ itself has benefits beyond simple measurement—it is a tool to ensure regular assessment and the consistent questioning can teach children and/or their parents which symptoms and experiences should be anticipated for managing their asthma.

**Outcome Measure Valuation:**
The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

---


### Related Category 1 or 2 Projects:

- **Starting Point/Baseline:**
  - To be determined during DY3.

### Year 2 (10/1/2012 – 9/30/2013)
- **Process Milestone 1 [P-1]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - Data Source: Project reports and documents
  - Process Milestone 1 Estimated Incentive Payment: $160,712

### Year 3 (10/1/2013 – 9/30/2014)
- **Process Milestone 2 [P-2]:** Establish baseline rates for number of children with an asthma diagnosis and initial scores on the ATAQ
  - Data Source: Provider reports
  - Process Milestone 2 Estimated Incentive Payment: $93,144

### Year 4 (10/1/2014 – 9/30/2015)
- **Outcome Improvement Target 1 [IT-1.20]:** Increase by 3% over baseline the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months.
  - Data Source: ATAQ, EHR
  - Outcome Improvement Target 1 Estimated Incentive Payment: $298,925

### Year 2 (10/1/2012 – 9/30/2013)
- **Outcome Improvement Target 2 [IT-1.20]:** Increase by 5% over baseline the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months.
  - Data Source: ATAQ, EHR
  - Outcome Improvement Target 2 Estimated Incentive Payment: $714,820

### Year 2 Estimated Outcome Amount:
- **$160,712**

### Year 3 Estimated Outcome Amount:
- **$186,287**

### Year 4 Estimated Outcome Amount:
- **$298,925**

### TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,360,744
**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease Management

**Performing Provider:** Memorial Hermann Hospital/TPI 137805107

**Unique RHP outcome identification number(s):** 137805107.3.7

**Outcome Measure Description:**
IT-1.1 Third next available appointment (Non-standalone measure)
Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient, or return visit/exam. The goals will be to decrease number of days to third next available appointment to two days for Specialty Care.

**Process Milestones:**
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
DY4:
IT-1.1 Reduce by 1 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days.
DY5:
IT-1.1 Reduce by 2 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to one day.

**Rationale:**
Access to care services can have an impact on healthcare outcomes, by providing early screening and treatment, patients are more likely to get these services when they are able to get appointments when first needed that accomodate their schedule. Since the goal of the project is to increase access to care and the third next available appointment is the healthcare industry's standard measure of access to care, we have chosen this outcome measure.
**Outcome Measure Valuation:**

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>137805107.3.7</th>
<th>3.IT-1.1</th>
<th>Third next available appointment (Non-standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memorial Hermann Hospital</td>
<td>137805107.1.4</td>
<td>137805107</td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:** 137805107.1.4

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Starting Point/Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
</tr>
</tbody>
</table>

**Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans**

- Data Source: Project reports and documents
- Process Milestone 1 Estimated Incentive Payment: $160,712

**Process Milestone 2 [P-2]: Establish baseline rates for number of children with an asthma diagnosis and initial scores on the ATAQ**

<table>
<thead>
<tr>
<th>Year</th>
<th>Process Milestone 2 Estimated Incentive Payment: $93,144</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
</tr>
</tbody>
</table>

**Process Milestone 3 [P-3]: Develop and test data systems**

- Data Source: Project reports, EMR, claims
- Process Milestone 3 Estimated Incentive Payment: $93,143

**Outcome Improvement Target 1 [IT-1.1]: Reduce by 1 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care.**

<table>
<thead>
<tr>
<th>Year</th>
<th>Outcome Improvement Target 1 Estimated Incentive Payment: $298,925</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
</tr>
</tbody>
</table>

**Outcome Improvement Target 2 [IT-1.1]: Reduce by 2 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care.**

<table>
<thead>
<tr>
<th>Year</th>
<th>Outcome Improvement Target 2 Estimated Incentive Payment: $714,820</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Outcome Amount:** $160,712

**Year 3 Estimated Outcome Amount:** $186,287

**Year 4 Estimated Outcome Amount:** $298,925

**Year 5 Estimated Outcome Amount:** $714,820

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,360,743
**Title of Outcome Measure (Improvement Target):** OD-9 Right Care, Right Setting

**Performing Provider:** Memorial Hermann Hospital/TPI 137805107

**Unique RHP outcome identification number(s):** 137805107.3.8

**Outcome Measure Description:**
IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits (Standalone measure)
Numerator: Percentage of clinic patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period. Denominator: Denominator is all clinic patients age two through age 18, diagnosed with asthma during the measurement period. The denominator will include recipients with claims with asthma as primary or secondary diagnoses with the dates of service being within the measurement period.

**Process Milestones:**
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
DY4:
IT-9.3 Reduce by 3% the percentage of Emergency Department (ED) visits for asthma in the target population.
DY5:
IT-9.3 Reduce by 5% the percentage of Emergency Department visits for asthma in the target population.

**Rationale:**
Asthma is one of the most common chronic illnesses among children in the U.S.\(^\text{16}\) Access to primary care services will have an impact on healthcare outcomes by providing early screening and treatment. The goal of the project is to increase access to primary care, thereby making sure patients get the right care at the right setting at the right time. Appropriate primary care has the potential to prevent the acute worsening of the chronic illnesses such as asthma, thereby

decreasing the need for emergency care. Hence ED visits for asthma will be a good outcome measure for this project.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>137805107.3.8</th>
<th>3.IT-9.3</th>
<th>Pediatric/Young Adult Asthma Emergency Department Visits (Stand-alone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>137805107.1.4</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
<td>To be determined during DY3.</td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
<td>Outcome Improvement Target 1 [IT-9.3]: Reduce by 3% the percentage of Emergency Department visits for asthma in the target population.</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: EMR, Claims</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 160,712</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 93,143</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 298,924</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 160,712</td>
<td>Year 3 Estimated Outcome Amount: $ 186,286</td>
<td>Year 4 Estimated Outcome Amount: $ 298,924</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 1,360,743
**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease Management

**Performing Provider:** Memorial Hermann Hospital/TPI 137805107

**Unique RHP outcome identification number(s):** 137805107.3.9

**Outcome Measure Description:**
IT-1.1 Third next available appointment (Non-standalone measure)
Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient, or return visit/exam. The goals will be to decrease number of days to third next available appointment to two days for Specialty Care.

**Process Milestones:**
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
DY4:
IT-1.1 Reduce by 1 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days.
DY5:
IT-1.1 Reduce by 2 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to one day.

**Rationale:**
Access to care services can have an impact on healthcare outcomes, by providing early screening and treatment, patients are more likely to get these services when they are able to get appointments when first needed that accomodate their schedule. Since the goal of the project is to increase access to care and the third next available appointment is the healthcare industry's standard measure of access to care, we have chosen this outcome measure.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>137805107.5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>To be determined during DY3.</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
</tr>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td></td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 160,712</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 [P-2]: Establish baseline rates for number of children with an asthma diagnosis and initial scores on the ATAQ</td>
<td></td>
</tr>
<tr>
<td>Data Source: Provider reports</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $ 93,144</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
<td></td>
</tr>
<tr>
<td>Data Source: Project reports, EMR, claims</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $ 93,143</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 1 [IT-1.1]: Reduce by 1 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care.</td>
<td></td>
</tr>
<tr>
<td>Data Source: Appointment management system</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 298,925</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 160,712</td>
<td></td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount: $ 186,287</td>
<td></td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount: $ 298,925</td>
<td></td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount: $ 714,820</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 1,360,743
**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease Management

**Performing Provider:** Memorial Hermann Hospital/TPI 137805107

**Unique RHP outcome identification number(s):** 137805107.3.10

**Outcome Measure Description:**
IT-1.20 Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Standalone)
Increase the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months as measured by the Asthma Therapy Assessment Questionnaire (ATAQ).\(^{17,18,19}\) The ATAQ was found to have “good internal consistency and strong relationships with existing validated measures of childhood health status, asthma impact, and health care utilization.”\(^{20}\) The score range on the 7-item ATAQ is 0-7, with 0 showing complete control and each score of 1 thereafter indicating an area in need of improved management. The ATAQ will be administered at each patient visit for patients with a diagnosis of asthma. Improvement is defined as a downward trend in the total score of the 7-items on the ATAQ for each individual patient.

**Process Milestones:**
DY2:
P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-2: Establish baseline rates
P-3: Develop and test data systems

**Outcome Improvement Targets for each year:**
DY4:
IT-1.20: Increase by 3% over baseline the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months.

DY5:
IT-1.20: Increase by 5% over baseline the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months.


\(^{19}\) Barbara P. Yawn, Susan K. Brenneman, Felicia C. Allen-Ramey, Michael D. Cabana and Leona E. Markson. Assessment of Asthma Severity and Asthma Control in Children. Pediatrics 2006;118;322

\(^{20}\) Ibid.
**Rationale:**
Asthma is one of the most common chronic illnesses among children in the U.S.\(^{21}\) The National Health Interview Survey (2011) found that 14% of all children living in the U.S., 21% of non-Hispanic black children, and 18% of children in poor families had ever been diagnosed with asthma.\(^{22}\) The number of children residing in the defined service area for this clinic is estimated at over 35,000, with 35% of those being non-Hispanic black (over 12,250) and 49% living below the federal poverty level (over 15,000). (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties.) By extrapolating the U.S. statistics on children with asthma to the service area for this clinic, we can conservatively estimate that there are at least 2,700 children in this area suffering from asthma. Since the service area for this clinic has a high proportion of children living below the federal poverty level and a high proportion of non-Hispanic black children, achieving better asthma control for these patients will be an important and worthy outcome measure of increasing access to primary care services.

After the assessment of severity for the initial diagnosis, the goal then becomes asthma control, demonstrated through symptom manifestation and disease activity. The use of the ATAQ itself has benefits beyond simple measurement—it is a tool to ensure regular assessment and the consistent questioning can teach children and/or their parents which symptoms and experiences should be anticipated for managing their asthma.\(^{23}\)

**Outcome Measure Valuation:**
The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

---


<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning</th>
<th>Process Milestone 2 [P-2]: Establish baseline rates for number of children with an asthma diagnosis and initial scores on the ATAQ</th>
<th>Outcome Improvement Target 1 [IT-1.20] Increase by 3% over baseline the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months.</th>
<th>Outcome Improvement Target 2 [IT-1.20] Increase by 5% over baseline the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Process Milestone 2 Estimated Incentive Payment: $93,144</td>
<td>Data Source: ATAQ, EHR</td>
<td>Data Source: ATAQ, EHR</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $160,712</td>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $298,925</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $714,820</td>
</tr>
<tr>
<td></td>
<td>Data Source: Project reports, EMR, claims</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Process Milestone 3 Estimated Incentive Payment: $93,143</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: $160,712</td>
<td>Year 3 Estimated Outcome Amount: $186,287</td>
<td>Year 4 Estimated Outcome Amount: $298,925</td>
<td>Year 2 Estimated Outcome Amount: $714,820</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,360,744
**Title of Outcome Measure (Improvement Target):** OD-9 Right Care, Right Setting

**Performing Provider:** Memorial Hermann Hospital/TPI 137805107

**Unique RHP outcome identification number(s):** 137805107.3.11

**Outcome Measure Description:**
IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits (Standalone measure)
Numerator: Percentage of clinic patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period. Denominator: Denominator is all clinic patients age two through age 18, diagnosed with asthma during the measurement period. The denominator will include recipients with claims with asthma as primary or secondary diagnoses with the dates of service being within the measurement period.

**Process Milestones:**
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
DY4:
IT-9.3 Reduce by 3% the percentage of Emergency Department (ED) visits for asthma in the target population.
DY5:
IT-9.3 Reduce by 5% the percentage of Emergency Department visits for asthma in the target population.

**Rationale:**
Asthma is one of the most common chronic illnesses among children in the U.S. Access to primary care services will have an impact on healthcare outcomes by providing early screening and treatment. The goal of the project is to increase access to primary care, thereby making sure patients get the right care at the right setting at the right time. Appropriate primary care has the potential to prevent the acute worsening of the chronic illnesses such as asthma, thereby decreasing the need for emergency care. Hence ED visits for asthma will be a good outcome measure for this project.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the

---

amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>137805107.3.11</th>
<th>3.IT-9.3</th>
<th>Pediatric/Young Adult Asthma Emergency Department Visits (Stand-alone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>137805107.1.5</td>
<td></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>To be determined during DY3.</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
<td>Outcome Improvement Target 1 [IT-9.3]: Reduce by 3% the percentage of Emergency Department visits for asthma in the target population.</td>
<td>Outcome Improvement Target 2 [IT-9.3]: Reduce by 5% the percentage of Emergency Department visits for asthma in the target population.</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: EMR, Claims</td>
<td>Data Source: EMR, Claims</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $160,712</td>
<td>Process Milestone 2 Estimated Incentive Payment: $93,143</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $298,924</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $714,820</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $160,712</td>
<td>Year 3 Estimated Outcome Amount: $186,286</td>
<td>Year 4 Estimated Outcome Amount: $298,924</td>
<td>Year 5 Estimated Outcome Amount: $714,820</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,360,743
Title of Outcome Measure (Improvement Target): IT-9.4: Other Outcome Improvement Target

Performing Provider: Memorial Hermann Hospital/TPI 137805107

Unique RHP outcome identification number(s): 137805107.3.12

Outcome Measure Description:
To achieve improvement under this metric, Memorial will engage in project planning during DY2. In DY3, Memorial will apply the planning developed in DY2 to determine baseline rates for future DYs. In DY4, Memorial intends to decrease the ED utilization rate described below by at least 5% under the baseline recorded in DY3. In DY5, Memorial intends to improve the rate by at least 10% under the baseline recorded in DY3.

Memorial will collect ED utilization data for patients enrolled in the patient navigation program which will be established by the Category 2 project associated with this Category 3 outcome. Memorial will collect this data by comparing the number of Memorial Hermann Health System ER visits in the six months prior to an individual’s enrollment in the patient navigation program with the number of Memorial Hermann Health System ER visits in the six months following the same individual’s enrollment.

Process Milestones:
- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans.
- DY3:
  - P-2: Establish baseline rates.

Outcome Improvement Targets for each year:
- DY4:
  - IT-9.4: Other Outcome Improvement Target—reduce Memorial Hermann ED visits in 6 months after enrollment in patient navigation program by 5% under DY3 baseline.
- DY5:
  - IT-9.4: Other Outcome Improvement Target—reduce Memorial Hermann ED visits in 6 months after enrollment in patient navigation program by 10% under DY3 baseline.

Rationale:
The greater Houston area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization. Memorial’s COPE/ED Navigation project (137805107.2.2) will provide patient navigation and offer alternatives to ED utilization for patients who may not be truly emergent. Memorial expects to see an improvement in ED utilization as a result of the associated Category 2 project.
**Outcome Measure Valuation:**
The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>Related Category 1 or 2 Projects:</td>
<td>Related Category 1 or 2 Projects:</td>
<td>Related Category 1 or 2 Projects:</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Starting Point/Baseline:</td>
<td>Starting Point/Baseline:</td>
<td>Starting Point/Baseline:</td>
</tr>
<tr>
<td>IT-9.4</td>
<td>IT-9.4</td>
<td>IT-9.4</td>
<td>IT-9.4</td>
</tr>
<tr>
<td><strong>Other Outcome Improvement Target</strong></td>
<td><strong>Other Outcome Improvement Target</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
</tr>
<tr>
<td><strong>Memorial Hermann Hospital</strong></td>
<td><strong>Memorial Hermann Hospital</strong></td>
<td><strong>[IT-9.4]: Other outcome improvement target.</strong></td>
<td><strong>[IT-9.4]: Other outcome improvement target.</strong></td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans.</strong></td>
<td><strong>Process Milestone 2 [P-2]: Establish baseline rates.</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 2</strong></td>
</tr>
<tr>
<td><strong>Data Source: Documentation of project planning.</strong></td>
<td><strong>Data Source: HER, Patient Navigation Database</strong></td>
<td><strong>[IT-9.4]: Other outcome improvement target.</strong></td>
<td><strong>[IT-9.4]: Other outcome improvement target.</strong></td>
</tr>
<tr>
<td><strong>Process Milestone 1: Estimated Incentive Payment: $434,396</strong></td>
<td><strong>Process Milestone 3: Estimated Incentive Payment: $503,522</strong></td>
<td><strong>[IT-9.4]: Other outcome improvement target.</strong></td>
<td><strong>[IT-9.4]: Other outcome improvement target.</strong></td>
</tr>
<tr>
<td><strong>Data Source: Documentation of project planning.</strong></td>
<td><strong>Process Milestone 3: Estimated Incentive Payment: $503,522</strong></td>
<td><strong>[IT-9.4]: Other outcome improvement target.</strong></td>
<td><strong>[IT-9.4]: Other outcome improvement target.</strong></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount: $434,396</strong></td>
<td><strong>Year 3 Estimated Outcome Amount: $503,522</strong></td>
<td><strong>[IT-9.4]: Other outcome improvement target.</strong></td>
<td><strong>[IT-9.4]: Other outcome improvement target.</strong></td>
</tr>
<tr>
<td><strong>Year 4 Estimated Outcome Amount: $807,976</strong></td>
<td><strong>Year 5 Estimated Outcome Amount: $1,932,118</strong></td>
<td><strong>[IT-9.4]: Other outcome improvement target.</strong></td>
<td><strong>[IT-9.4]: Other outcome improvement target.</strong></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $3,678,012</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $3,678,012</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $3,678,012</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $3,678,012</td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): IT-13.3: Proportion with More Than One Emergency Room Visit in the Last Days of Life

Performing Provider: Memorial Hermann Hospital/TPI 137805107

Unique RHP outcome identification number(s): 137805107.3.13

Outcome Measure Description:
To achieve improvement under this metric, Memorial will engage in project planning during DY 2. In DY 3, Memorial will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Memorial intends to improve its proportion of patients who died from cancer with more than one emergency room visit in the last days of life by at least 10% over the baseline recorded in DY 3. In DY 5, Memorial intends to improve the measure by at least 10% over DY 4.

Process Milestones:
- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3:
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year:
- DY4:
  - IT-13.3: Proportion with more than one emergency room visit in the last days of life—5% improvement over baseline
- DY5:
  - IT-13.3: Proportion with more than one emergency room visit in the last days of life—10% improvement over baseline

Rationale:
Due to a lack of access to hospice and palliative care, many patients have no choice but to receive end-of-life care which focuses on cure at any cost, rather than on the relief and prevention of suffering. In the last days of life, these patients often receive emergency treatment that is inconsistent with palliative care principles and without proper regard for the patient’s quality of life. Memorial’s Palliative Clinical Care Program project (137805107.2.2) will accelerate the growth and increase availability of palliative care in the greater Houston area, providing an alternative to ED utilization for patients in the last days of life. Memorial therefore expects to see an improvement in this Category 3 outcome as a result of the successful implementation of the associated Category 1 project.

Outcome Measure Valuation:
The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.
<table>
<thead>
<tr>
<th>137805107.3.13</th>
<th>IT-13.3</th>
<th>Proportion with More Than One Emergency Room Visit in the Last Days of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Memorial Hermann Hospital</strong></td>
<td>137805107</td>
<td></td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:**

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>TBD</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning.</td>
<td><strong>Process Milestone 2 [P-2]:</strong> Establish baseline rates. Data Source: EHR; claims.</td>
<td><strong>Outcome Improvement Target 1 [IT-13.3]:</strong> Proportion with more than one emergency room visit in the last days of life (NQF 0211). Improvement Target: 5% improvement over baseline. Data Source: EHR; claims.</td>
<td><strong>Outcome Improvement Target 2 [IT-13.3]:</strong> Proportion with more than one emergency room visit in the last days of life (NQF 0211). Improvement Target: 10% improvement over baseline. Data Source: EHR; claims.</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $420,075</td>
<td>Process Milestone 3 Estimated Incentive Payment: $486,972</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $781,340</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $1,868,421</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $420,075</td>
<td>Year 3 Estimated Outcome Amount: $486,972</td>
<td>Year 4 Estimated Outcome Amount: $781,340</td>
<td>Year 5 Estimated Outcome Amount: $1,868,421</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $3,556,758
Memorial Hermann Northwest Hospital
Pass 1
Title of Outcome Measure (Improvement Target): IT-7.2 Cavities: Percentage of children with untreated dental caries (Healthy People 2020); and IT-1.1 Third next available appointment.

Unique RHP outcome identification number(s): 020834001.3.1

Outcome Measure Description:
To achieve improvement under this metric, Memorial Hermann will engage in project planning during DY 2. In DY 3, Memorial Hermann will apply the planning developed in DY 2 in order to determine baseline rates for future DYS. In DY 4, Memorial Hermann intends to improve the untreated dental caries measurement defined below by at least 15% over the baseline recorded in DY 3 for that measurement. In DY 5, Memorial Hermann intends to improve the same measurement by at least 25% over baseline. Additionally, Memorial Hermann will ensure that patients have convenient access to primary care services by maintaining the third next available appointment be no more than 3 days from a patient’s request 75% of the time.

Process Milestones:
- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3:
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year:
- DY4:
  - IT-7.2 Cavities: Percentage of children with untreated dental caries (Healthy People 2020)—15% improvement over DY3 in recall patients
    - Numerator: Number of children with untreated dental caries seen by the mobile dental van program within the measurement period
    - Denominator: Total number of children that have been seen by the mobile dental van program within the measurement period
  - IT-1.1 Third Next Available Appointment: Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. Maintain number of days to third next available appointment to no more than three days 75% of the time.
    - Numerator: Average number of days to third next available appointment for an office visit for each clinic.
    - Denominator: Mid-level provider within a reported clinic.
    - Exclusions: weekends
- DY5:
  - IT-7.2 Cavities: Percentage of children with untreated dental caries (Healthy People 2020—25% improvement over baseline
    - Numerator: Number of children with untreated dental caries seen by the mobile dental van program within the measurement period
• Denominator: Total number of children that have been seen by the mobile dental van program within the measurement period
  o IT-1.1 Third Next Available Appointment: Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. Maintain number of days to third next available appointment to no more than three days 75% of the time.
  • Numerator: Average number of days to third next available appointment for an office visit for each clinic.
  • Denominator: Mid-level provider within a reported clinic.
  • Exclusions: weekends

**Rationale:**
The greater Houston area faces several major healthcare challenges, including a lack of primary care capacity, which can result in care completely foregone until medical and dental issues escalate leading to negative utilization patterns such as ED overutilization. Memorial Hermann’s School-Based Health project (020834001.1.1) will provide alternatives to improper ED utilization and provide the right care in the right setting through consistent delivery of preventive care. Therefore, Memorial Hermann expects to see an improvement in the defined outcome improvement target as a result of the successful implementation of the associated Category 1 project. This specific improvement target has been chosen, in part, because it exemplifies the benefits to be derived from an accessible medical and dental home. Additionally, Memorial Hermann will sample the mid-level providers (MLP) the same day of the week, once a week. Count the number of days between a request for an appointment (enter a dummy patient) with an MLP and the third next available appointment for a new patient physical, routine exam, or return visit exam. Report the average number of days for all MLPs sampled. The data collection can be done manually or electronically. This will be done to maintain number of days to third next available appointment to no more than three days 75% of the time.

**Outcome Measure Valuation:**
The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>020834001.1.1</th>
<th>020834001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 2</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 3</strong></td>
</tr>
</tbody>
</table>
| [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans.  
  **Data Source:** Documentation of project planning. | [P-2]: Establish baseline rates.  
  **Data Source:** Dental Charts; Excel Report; EHR of initial patients | [IT-7.2]: Percentage of children with untreated dental caries.  
  Improvement Target: 15% improvement over baseline.  
  **Data Source:** Dental Charts; Excel Report of recall patients. | [IT-7.2]: Percentage of children with untreated dental caries.  
  Improvement Target: 25% improvement over baseline.  
  **Data Source:** Dental Charts; Excel Report of recall patients. |
| Process Milestone 1 Estimated Incentive Payment: $404,180 | Process Milestone 3 Estimated Incentive Payment: $468,497 | Outcome Improvement Target 1 Estimated Incentive Payment: $375,887 | Outcome Improvement Target 3 Estimated Incentive Payment: $898,860.5 |

<table>
<thead>
<tr>
<th><strong>Outcome Improvement Target 2</strong></th>
<th><strong>Outcome Improvement Target 4</strong></th>
</tr>
</thead>
</table>
| [IT-1.1]: Third next available appointment.  
  Improvement Target: Maintain number of days to third next available appointment to no more than three days 75% of the time.  
  **Numerator:** Average number of days to third next available appointment for an office visit for each clinic.  
  **Denominator:** Mid-level provider within a reported clinic.  
  **Data Source:** Appointment management system.  
  **Exclusions:** Weekends and approved family and medical | [IT-1.1]: Third next available appointment.  
  Improvement Target: Maintain number of days to third next available appointment to no more than three days 75% of the time.  
  **Numerator:** Average number of days to third next available appointment for an office visit for each clinic.  
  **Denominator:** Mid-level provider within a reported clinic.  
  **Data Source:** Appointment management system.  
  **Exclusions:** Weekends and approved family and medical |
<table>
<thead>
<tr>
<th>020834001.3.1</th>
<th>IT-7.2</th>
<th>Cavities: Percentage of children with untreated dental caries</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT-1.1</td>
<td></td>
<td>Third next available appointment</td>
</tr>
<tr>
<td>Memorial Hermann Hospital System</td>
<td>020834001.1.1</td>
<td>020834001</td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:** 020834001.1.1

**Starting Point/Baseline:** TBD in DY3

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome Improvement Target 2 approved family and medical leave.</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $375,887</td>
<td>Outcome Improvement Target 4 Estimated Incentive Payment: $898,860.5</td>
<td></td>
</tr>
</tbody>
</table>

**Year 2 Estimated Outcome Amount:** $404,180

**Year 3 Estimated Outcome Amount:** $468,497

**Year 4 Estimated Outcome Amount:** $751,774

**Year 5 Estimated Outcome Amount:** $1,797,721

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $3,422,172
**Title of Outcome Measure (Improvement Target):** IT-9.2: ED appropriate utilization

**Performing Provider:** Memorial Hermann Hospital System/TPI 020834001

**Unique RHP outcome identification number(s):** 020834001.3.2

**Outcome Measure Description:**
To achieve improvement under this metric, Memorial Hermann will engage in project planning during DY 2. In DY 3, Memorial Hermann will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. Over the program period, Memorial Hermann will achieve a 25% reduction in ER visits from the individuals who call the Nurse Triage Line who would have used the ER inappropriately. Callers who were identified by Nurses as non-emergent will be surveyed by telephone within 7 days of their call to assess patient compliance with staff recommendations, the patient’s actual healthcare actions, and their satisfaction with the service. The program’s Community Health Workers (CHWs) or Navigators will make the follow-up calls as part of their navigation work to assist patients in making clinic connections and to link patients with other community resources as needed.

**Process Milestones:**
- **DY2:**
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- **DY3:**
  - P-2: Establish baseline rates

**Outcome Improvement Targets for each year:**
- **DY4:**
  - IT-9.2: ED appropriate utilization – 15% of nurse triage calls will be ER diverted over the baseline measured in DY 2
    - Numerator:
      - Number of Nurse Triage Calls resulting in ED avoidance over a 12 month period
    - Denominator:
      - Number of Nurse Triage Calls received in a 12 month period.
- **DY5:**
  - IT-9.2: ED appropriate utilization – 25% of nurse triage calls will be ER diverted over the baseline measured in DY 2
    - Numerator:
      - Number of Nurse Triage Calls resulting in ED avoidance over a 12 month period
    - Denominator:
      - Number of Nurse Triage Calls received in a 12 month period.

**Rationale:**
The greater Houston area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization.
Memorial Hermann’s 24-Hour Nurse Triage Line project (020834001.1.2) will provide an alternative to ED utilization for patients who may not be truly emergent; therefore, Memorial Hermann expects to see an improvement in ED utilization as a result of the associated Category 1 project. Percentage improvement is based on volume of calls which are anticipated to increase in the fourth year (from baseline) and the fifth year of the project.

**Outcome Measure Valuation:**
The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.
<table>
<thead>
<tr>
<th>Year 2  (10/1/2012 – 9/30/2013)</th>
<th>Year 3  (10/1/2013 – 9/30/2014)</th>
<th>Year 4  (10/1/2014 – 9/30/2015)</th>
<th>Year 5  (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]: Project planning</strong>—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning. Process Milestone 1 Estimated Incentive Payment: $408,879</td>
<td><strong>Process Milestone 2 [P-2]: Establish baseline rates.</strong> Data Source: EHR; Triage Line Software. Process Milestone 3 Estimated Incentive Payment: $473,945</td>
<td><strong>Outcome Improvement Target 1 [IT-9.2]: ED Appropriate Utilization</strong> 15% of nurse triage calls will be ER diverted over the baseline measured in DY 2. Data Source: Follow up surveys from CHWs. Outcome Improvement Target 1 Estimated Incentive Payment: $760,516</td>
<td><strong>Outcome Improvement Target 2 [IT-9.2]: ED Appropriate Utilization Improvement Target</strong> 25% of nurse triage calls will be ER diverted over the baseline measured in DY 2. Data Source: Follow up surveys from CHWs. Outcome Improvement Target 2 Estimated Incentive Payment: $1,818,625</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $408,879</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $473,945</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $760,516</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $1,818,625</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $3,461,964
Title of Outcome Measure (Improvement Target): IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate

Unique RHP outcome identification number(s): 020834001.3.3

Outcome Measure Description:
To achieve improvement under this metric, Memorial Hermann will engage in project planning during DY 2. In DY 3, Memorial Hermann will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Memorial Hermann intends to reduce its Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate by at least 5% over the baseline recorded in DY 3. In DY 5, Memorial Hermann intends to improve its BH/SA 30-day readmission rate by at least 5% over the DY 4 measurement.

Process Milestones:
- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3:
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year:
- DY4:
  - IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate—5% reduction over DY3
- DY5:
  - IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate—10% reduction over the baseline measures in DY3

Rationale:
Behavioral health patients in the greater Houston area, particularly uninsured patients, face significant challenges in obtaining the behavioral health care services they need, which can result in negative utilization patterns including unnecessary inpatient admissions. These challenges will be addressed by Memorial Hermann’s Psych Response Team—Case Management project (020834001.2.1), which will result in more intensive case management of post-discharge behavioral health patients and more appropriate follow-up and utilization of care by these patients. That care will be provided in a community setting, in part, through Memorial Hermann’s efforts to implement a Home Health Psych Services project (020834001.1.3). Therefore, Memorial Hermann expects to see an improvement in the Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate as a result of the associated Category 1 and 2 projects.

Current national data available indicates patients with a mental health diagnosis hospitalized in a given year will seek readmission within the same year 10% more than the general population (Smeltzer, 2009). Data collected from Memorial Hermann’s facilities indicate 35% of psychiatric care is delivered without comprehensive behavioral health services available to the
patient. Providing mental health services in the home setting will increase access to mental health services delivered in an appropriate setting and decrease the readmission of these patients.

**Project Valuation:**

The valuation of Memorial Hermann’s projects use a method which ranks the importance of each projects based several key factors. First, Memorial Hermann considered the extent the project helps further the goals of the Waiver, which are to (a) enhance access to health care, (b) increase the quality of care, and (c) improve the cost-effectiveness of care provided in the community. Next, Memorial Hermann considered the degree of need for the project in the community as addressed and identified in the Community Needs Assessment. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity as well as the cost of the time, effort, and clinical resources involved in implementing the project. Finally, Memorial Hermann reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the ripple effect the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available. We believe this approach is the best methodology available to assess the impact of the project, the investment of the performing provider and the overall value to the community to the extent community resources are available to help fund DSRIP projects. Final project valuation and funding distribution across categories was then determined based on the valuation provisions in the Program Funding and Mechanics Protocol.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>020834001.1.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Process Milestone 1 [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning.</th>
<th>Process Milestone 2 [P-2]: Establish baseline rates. Data Source: EHR; claims.</th>
<th>Outcome Improvement Target 1 [IT-3.8]: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate. Improvement Target: 5% improvement over DY3. Data Source: EHR; claims.</th>
<th>Outcome Improvement Target 2 [IT-3.8]: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate. Improvement Target: 10% improvement over baseline. Data Source: EHR; claims.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $484,076</td>
<td>Process Milestone 3 Estimated Incentive Payment: $561,107</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $900,381</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $2,153,084</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $4,098,647
**Title of Outcome Measure (Improvement Target):** ITIT-1.10 Diabetes care: HBA1c poor control (>9.0%)

**Performing Provider:** Memorial Hermann Hospital System/TPI 020834001

**Unique RHP outcome identification number(s):** 020834001.3.4

**Outcome Measure Description:**
To achieve improvement under this metric, Memorial Hermann will engage in project planning during DY 2. In DY 3, Memorial Hermann will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Memorial Hermann intends to improve the management of the diabetes population by 3% on the HBA1c scale. In DY 5, Memorial Hermann intends to improve the management of the diabetes population by 5% on the HBA1c scale.

**Process Milestones:**
- **DY2:**
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- **DY3:**
  - P-2: Establish baseline rates

**Outcome Improvement Targets for each year:**
- **DY4:**
  - IT-1.10 Increase % of patients with A1c <9% over baseline by 3%
  - DY5: IT-1.10 Increase % of patients with A1c <9% over baseline by 5%  

**Rationale:**
The greater Houston area faces several major healthcare challenges, including a lack of primary care capacity, which results in poor management of chronic conditions that are prevalent in the population like diabetes. This challenge will be addressed by Memorial Hermann’s Convenient Care Centers project (020834001.1.4), and in the Agency for Healthcare Research and Quality’s 2011 report, Texas ranks last in the nation on health care quality. In the same report, Texas scored particularly weak on diabetes care. Process milestones 1 & 2 were chosen to take our current patient population and calculate a baseline rate of % of patients with diabetes that have an A1C <9%.

This is a relevant outcome measure for project 1.1.2 for Convenient Care Centers because by adding incremental primary care sites, we will care for more of our RHP patient population and yet have a mechanism in place to monitor and improve their diabetes control through focused follow up care by our primary care physicians. Improvement target is the measure itself and we want to grow the % < 9% which indicates the patient’s diabetes is in control.

**Outcome Measure Valuation:**
The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs...
avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

Focus on successful management resulting in reduced # of patients with A1c > 9 improves the patient health status, reduces costs and avoids admissions, thus creating greater access for the RHP 3 underserved patient population.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning. Process Milestone 1 Estimated Incentive Payment: $488,775</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates. Data Source: Patient survey. Process Milestone 3 Estimated Incentive Payment: $566,554</td>
<td>Outcome Improvement Target 1 [ Improvement Target: Calculate % of patients with A1c &lt; 9% with a 3% improvement over baseline as goal Data Source: Patient Records Outcome Improvement Target 1 Estimated Incentive Payment: $909,122</td>
<td>Outcome Improvement Target 2. Improvement Target: Calculate % of patients with A1c &lt; 9% with a 3% improvement over baseline as goal Data Source: Patient Records Outcome Improvement Target 2 Estimated Incentive Payment: $2,173,988</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $488,775</td>
<td>Year 3 Estimated Outcome Amount: $566,554</td>
<td>Year 4 Estimated Outcome Amount: $909,122</td>
<td>Year 5 Estimated Outcome Amount: $2,173,988</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $4,138,440
**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease Management

**Performing Provider Name/TPI:** Memorial Hermann Hospital System/020834001

**Unique RHP outcome identification number(s):** 020834001.3.5

**Outcome Measure Description:**
IT-1.1 Third next available appointment (Non-standalone measure)
Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient, or return visit/exam. The goals will be to decrease number of days to third next available appointment to two days for Specialty Care.

**Process Milestones:**
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
DY4:
IT-1.1 Reduce by 1 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days.
DY5:
IT-1.1 Reduce by 2 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to one day.

**Rationale:**
Access to care services can have an impact on healthcare outcomes, by providing early screening and treatment, patients are more likely to get these services when they are able to get appointments when first needed that accomodate their schedule. Since the goal of the project is to increase access to care and the third next available appointment is the healthcare industry's standard measure of access to care, we have chosen this outcome measure.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration
year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates for number of children with an asthma diagnosis and initial scores on the ATAQ</td>
<td>Outcome Improvement Target 1 [IT-1.1]: Reduce by 1 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care.</td>
<td>Outcome Improvement Target 2 [IT-1.1]: Reduce by 2 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care.</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: Appointment management system</td>
<td>Data Source: Appointment management system</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 175,602</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 101,804</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 327,649</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 791,533</td>
</tr>
<tr>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
<td>Process Milestone 3 Estimated Incentive Payment: $ 101,803</td>
<td>Data Source: Project reports, EMR, claims</td>
<td>Data Source: Appointment management system</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 175,602</td>
<td>Year 3 Estimated Outcome Amount: $ 203,607</td>
<td>Year 4 Estimated Outcome Amount: $ 327,649</td>
<td>Year 5 Estimated Outcome Amount: $ 791,533</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 1,498,391
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Performing Provider Name/TPI: Memorial Hermann Hospital System/ 020834001

Unique RHP outcome identification number(s): 020834001.3.6

Outcome Measure Description:
IT-1.20 Asthma Control in Pediatric Patients Using the Asthma Therapy Assessment Questionnaire (ATAQ) (Standalone)
Increase the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months as measured by the Asthma Therapy Assessment Questionnaire (ATAQ).¹²³ The ATAQ was found to have “good internal consistency and strong relationships with existing validated measures of childhood health status, asthma impact, and health care utilization.”⁴ The score range on the 7-item ATAQ is 0-7, with 0 showing complete control and each score of 1 thereafter indicating an area in need of improved management. The ATAQ will be administered at each patient visit for patients with a diagnosis of asthma. Improvement is defined as a downward trend in the total score of the 7-items on the ATAQ for each individual patient.

Process Milestones:
DY2:
P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-2: Establish baseline rates
P-3: Develop and test data systems

Outcome Improvement Targets for each year:
DY4:
IT-1.20: Increase by 3% over baseline the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months.
DY5:
IT-1.20: Increase by 5% over baseline the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months.

⁴ Ibid.
Rationale:
Asthma is one of the most common chronic illnesses among children in the U.S. The National Health Interview Survey (2011) found that 14% of all children living in the U.S., 21% of non-Hispanic black children, and 18% of children in poor families had ever been diagnosed with asthma. The number of children residing in the defined service area for this clinic is estimated at over 35,000, with 35% of those being non-Hispanic black (over 12,250) and 49% living below the federal poverty level (over 15,000). (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties.) By extrapolating the U.S. statistics on children with asthma to the service area for this clinic, we can conservatively estimate that there are at least 2,700 children in this area suffering from asthma. Since the service area for this clinic has a high proportion of children living below the federal poverty level and a high proportion of non-Hispanic black children, achieving better asthma control for these patients will be an important and worthy outcome measure of increasing access to primary care services.

After the assessment of severity for the initial diagnosis, the goal then becomes asthma control, demonstrated through symptom manifestation and disease activity. The use of the ATAQ itself has benefits beyond simple measurement—it is a tool to ensure regular assessment and the consistent questioning can teach children and/or their parents which symptoms and experiences should be anticipated for managing their asthma.

Outcome Measure Valuation:
The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
</tr>
</thead>
</table>
| **Process Milestone 1 [P-1]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans | **Process Milestone 2 [P-2]:** Establish baseline rates for number of children with an asthma diagnosis and initial scores on the ATAQ  
Data Source: Provider reports | **Outcome Improvement Target 1 [IT-1.20]:** Increase by 3% over baseline the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months.  
Data Source: ATAQ, EHR | **Outcome Improvement Target 2 [IT-1.20]:** Increase by 5% over baseline the percent of members (ages 5-17) diagnosed with asthma that showed improvement in asthma control over the previous 12 months.  
Data Source: ATAQ, EHR |
| **Data Source:** Project reports and documents | **Process Milestone 2 Estimated Incentive Payment:** $ 101,804 | **Outcome Improvement Target 1 Estimated Incentive Payment:** $327,650 | **Outcome Improvement Target 2 Estimated Incentive Payment:** $791,533 |
| **Process Milestone 1 Estimated Incentive Payment:** $ 175,602 | **Process Milestone 3 [P-3]:** Develop and test data systems  
Data Source: Project reports, EMR, claims | **Outcome Improvement Target 1 Estimated Incentive Payment:** $327,650 | **Outcome Improvement Target 2 Estimated Incentive Payment:** $791,533 |
| **Year 2 Estimated Outcome Amount:** $ 175,602 | **Year 3 Estimated Outcome Amount:** $ 203,607 | **Year 4 Estimated Outcome Amount:** $ 327,650 | **Year 2 Estimated Outcome Amount:** $791,533 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 1,498,391
Title of Outcome Measure (Improvement Target): OD-9 Right Care, Right Setting

Performing Provider Name/TPI: Memorial Hermann Hospital System/ 020834001

Unique RHP outcome identification number(s): 020834001.3.7

Outcome Measure Description:
IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits (Standalone measure)
Numerator: Percentage of clinic patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period. Denominator: Denominator is all clinic patients age two through age 18, diagnosed with asthma during the measurement period. The denominator will include recipients with claims with asthma as primary or secondary diagnoses with the dates of service being within the measurement period.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-9.3 Reduce by 3% the percentage of Emergency Department (ED) visits for asthma in the target population.
DY5:
IT-9.3 Reduce by 5% the percentage of Emergency Department visits for asthma in the target population.

Rationale:
Asthma is one of the most common chronic illnesses among children in the U.S. Access to primary care services will have an impact on healthcare outcomes by providing early screening and treatment. The goal of the project is to increase access to primary care, thereby making sure patients get the right care at the right setting at the right time. Appropriate primary care has the potential to prevent the acute worsening of the chronic illnesses such as asthma, thereby decreasing the need for emergency care. Hence ED visits for asthma will be a good outcome measure for this project.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the

---

amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
  Data Source: Project reports and documents | Process Milestone 2 [P-2]: Establish baseline rates  
  Data Source: Provider reports | Outcome Improvement Target 1 [IT-9.3]: Reduce by 3% the percentage of Emergency Department visits for asthma in the target population.  
  Data Source: EMR, Claims | Outcome Improvement Target 2 [IT-9.3]: Reduce by 5% the percentage of Emergency Department visits for asthma in the target population.  
  Data Source: EMR, Claims |
| Year 2 Estimated Outcome Amount: $175,602 | Year 3 Estimated Outcome Amount: $203,606 | Year 4 Estimated Outcome Amount: $327,649 | Year 5 Estimated Outcome Amount: $791,532 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,498,390
Title of Outcome Measure (Improvement Target): IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate

Performing Provider: Memorial Hermann Hospital System/TPI 020834001

Unique RHP outcome identification number(s): 020834001.3.8

Outcome Measure Description:
To achieve improvement under this metric, Memorial Hermann will engage in project planning during DY2. In DY3, Memorial Hermann will apply the planning developed in DY2 in order to determine baseline rates for future DYs. In DY4, Memorial Hermann intends to reduce its Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate by at least 5% over the baseline recorded in DY3. In DY5, Memorial Hermann intends to improve its BH/SA 30-day readmission rate by at least 10% over the baseline recorded in DY3.

Process Milestones:
- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3:
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year:
- DY4:
  - IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate—5% reduction over baseline recorded in DY3
- DY5:
  - IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate—10% reduction over baseline recorded in DY3

Rationale:
Behavioral health patients in the greater Houston area, particularly uninsured patients, face significant challenges in obtaining the behavioral health care services they need, which can result in negative utilization patterns including unnecessary inpatient admissions. These challenges will be addressed by Memorial Hermann’s Psych Response Team—Case Management project (020834001.2.1), which will result in more intensive case management of post-discharge behavioral health patients and more appropriate follow-up and utilization of care by these patients. That care will be provided in a community setting, in part, through Memorial Hermann’s efforts to implement a Home Health Psych Services project (020834001.1.1). Therefore, Memorial Hermann expects to see an improvement in the Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate as a result of the associated Category 1 and 2 projects.

Since 2007, the emergent psych patients seeking services at Memorial Hermann Health System acute care facilities increased annually by ~ 5% over the preceding year. Current national data available indicates patients with a mental health diagnosis hospitalized in a given year will seek readmission within the same year 10% more than the general population (Smeltzer, 2009).
Memorial Hermann Health System psych data indicates inpatient care is initiated for 35% of total psych volumes that do not have post discharge case management services available. (Memorial Hermann Health System Psych Volumes FY 12: 6924 patient encounters, 2423 patients were admitted to psych inpatient treatment). Initial contact with target population will be crucial to impacting patient outcome for reducing readmission rates. Once the program is developed, initial contact in the acute care setting will accomplish follow-up consent post discharge.

**Outcome Measure Valuation:**
The valuation of each Memorial Hermann project takes into account the transformational impact, the population served (both number of people and complexity of patient needs), the alignment with community needs, the magnitude of costs avoided or reduced, the degree of collaboration involved, and the sustainability of the project.

A national current practice review indicates post discharge follow-up decreases future inappropriate ER utilization in a range of 25%-60%. Translating these statistics with the most conservative approach is an outcome measure that would greatly impact inappropriate utilization of Memorial Hermann Health System ERs.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>020834001.2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
</tr>
</tbody>
</table>
**Data Source:** EHR; claims.  
Process Milestone 3 Estimated Incentive Payment: $539,316 |
| Year 3 (10/1/2013 – 9/30/2014) | Outcome Improvement Target 1 [IT-3.8]: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate.  
Improvement Target: 5% improvement over baseline.  
**Data Source:** EHR; claims.  
Outcome Improvement Target 1 Estimated Incentive Payment: $865,414 | Outcome Improvement Target 2 [IT-3.8]: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate.  
Improvement Target: 10% improvement over baseline  
**Data Source:** EHR; claims.  
Outcome Improvement Target 2 Estimated Incentive Payment: $2,069,469 |
| Year 4 (10/1/2014 – 9/30/2015) |               | Year 5 (10/1/2015 – 9/30/2016) |
| Year 2 Estimated Outcome Amount: $465,277 | Year 3 Estimated Outcome Amount: $539,316 | Year 4 Estimated Outcome Amount: $865,414 | Year 5 Estimated Outcome Amount: $2,069,469 |
| **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $3,939,477 |
Title of Outcome Measure (Improvement Target): IT-6.1: Percent Improvement Over Baseline of Patient Satisfaction Scores

Performing Provider: Memorial Hermann Hospital System/TPI 020834001

Unique RHP outcome identification number(s): 020834001.3.9

Outcome Measure Description:
To achieve improvement under this metric, Memorial Hermann will engage in project planning during DY2. In DY3, Memorial Hermann will apply the planning developed in DY2 to determine baseline rates for future DYs. In DY4, Memorial Hermann intends to improve its patient satisfaction scores over the baseline recorded in DY3 by using patients’ rating of whether they are getting timely care, appointments, and information. Targets for patient satisfaction scores will be gauged against emerging best practice standards and industry comparatives.

Process Milestones:
- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans.
- DY3:
  - P-2: Establish baseline rates.

Outcome Improvement Targets for each year:
- DY4:
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores—improvement over DY3 for patients’ rating of whether patients are getting timely care, appointments, and information.
- DY5:
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores—improvement over baseline for patients’ rating of whether patients are getting timely care, appointments, and information.

Rationale:
The greater Houston area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization. Improper utilization results in lower levels of patient satisfaction, since it is not the level or type of care most appropriate to the patient’s condition. Additionally, patients are often unaware of the utilization options that are available to them, or are otherwise not properly equipped to choose the best utilization options. These challenges will be addressed by Memorial Hermann’s Convenient Care Centers project and MHMD Care Management project, and Memorial Hermann expects to see an improvement in patient satisfaction as a result of the associated Category 1 and 2 projects—specifically, an improvement in patients’ rating of whether they are getting timely care, appointments, and information.

Outcome Measure Valuation:
The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs
avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $484,076</td>
<td>Year 3 Estimated Outcome Amount: $561,107</td>
<td>Year 4 Estimated Outcome Amount: $900,381</td>
<td>Year 5 Estimated Outcome Amount: $2,153,084</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $4,098,647
Memorial Medical Center
Pass 1
Title of Outcome Measure (Improvement Target): IT-6.1 Patient Satisfaction

Performing Provider/TPI: Memorial Medical Center/137909111
Unique RHP outcome identification number: 137909111.3.1

Project Description:
To increase the ability of Memorial Medical Center (MMC) to provide the “right care at the right time in the right setting,” patient satisfaction with primary and specialty care services through the establishment of a hospital-based clinic shall be essential. This “expanding access to care” initiative will provide critically needed services to a medically underserved area of rural Texas as identified in our Region’s community needs assessment. However, ensuring patients have access to services at times that are convenient for them, are able to secure appointments with appropriate providers, (therefore reducing the inappropriate use of the hospital emergency department for non-urgent and primary care service) are critical elements to producing life saving, as well as, cost saving measures.

Outcome Measure Description:
To progressively measure and implement appropriate changes, specific steps and milestones are integrated into Memorial Medical’s Center Access to Care four year plan. Following is synopsis of the selected milestones and associated metrics.

During DY2, when the infrastructure for a Hospital Based Clinic is under development, MMC shall assemble a team with Quality Assurance Council to review CG-CAHPS required data on patient experience. After review, the team shall meet with a vendor to develop a customized survey tool to measure and monitor patient outcomes. Open ended questions shall be developed on the survey to all patients to elaborate on their experiences and give insight on how those experiences may be improved. This process milestone is valued at $62,718 for staffing, design development, implementation and monitoring.

For demonstration year 3, we will establish the baseline rates for CG-CAHPS focused areas including timely care, appointments and information. Milestone 2 includes collecting the data from CG-CAHPS surveys and aligning our baseline of achievements or shortcomings to the national average, as well as, personal standards for MMC. We value milestone two at $22,698 for staffing, analysis, and monitoring. Milestone 3 launches a critical step to any successful program, disseminate findings and establish lessons learned and best practices with stakeholders. Utilizing our RHP resources, Quality Assurance Council and other identified stakeholder (i.e. office staff, Physicians, IT, etc.) scores will be aligned with procedures and protocols to develop best practices for positive patient outcomes. Data and feedback are ineffective unless studied, analyzed developed into strategic plans. Because of the importance of this milestone, we value this component at $50,000 for staffing, analysis, oversight and plan development.

In DY4, MMC shall incorporate the milestones in DY3 to produce targeted improvement outcomes in this project year. Target outcome one encompasses a 5% improvement over baseline patient satisfaction scores established in DY3. Focus areas include timely care, appointments and information where goals in patient experiences fell below acceptable standards. Based upon survey results, employee training shall be developed integrating patient experience into the curriculum. Stakeholders and RHP collaborations shall be encouraged to utilize successful models. Further, a case manager/educator shall be placed to assist in...
information and education for patients. We value this milestone at $116,655 including staffing, analyzing, customized curriculum, supplies, training, and monitoring.

Finally, in DY5, patient experience at the Hospital Based Clinic shall have improved in deficient areas of timely care, appointments and information by 10% by the end of the waiver. Further, 80% of staff in areas identified with deficiencies in patient satisfaction shall be trained using customized models for positive patient outcomes. Patient education and case management shall extend based upon customer needs. We value this DSRIP milestone at $278,957 including staffing, analyzing, customized curriculum, supplies, training, public awareness and monitoring.

**Rationale:**
We intend to use the CG-CAHPS survey to improve our performance as measured by whether patients are (1) getting timely care, appointments and information. Obtaining patient feedback on our ability to provide the right care at the right time is critical to the success of this project and the internal operations of the clinic. This data will provide us with meaningful and objective information that will be used to determine whether our clinic has met patient expectations related to obtaining timely care and information, and will identify areas where we need to improve.

Because the community we serve has an insufficient number of providers and patients are often unable to obtain appointments in a timely manner, the priority goal for this project is ensuring patients receive care when they need it and without significant delays, which will result in improved health outcomes and patient satisfaction. The CG-CAHPS survey is an effective tool for measuring our progress and will provide valuable information and feedback on our performance and areas where improvement is needed.

Because more than 60% of our community out-migrates for healthcare needs, it is important that patient satisfaction and access to care needs are met locally. Measuring that we are meeting the needs of the patients we intend to serve, represents the best outcome for our project. Through survey results and our participation in a collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

**Outcome Measure Valuation:**
When valuing the expansion of access to both primary and specialty care in Calhoun County, we looked at the project three-fold. We found such a project had significant economic, quality of life and cost savings value.

First, we surmised the economic value to the County as a whole, the patient, and industry. Roughly 70% of Calhoun County out-migrates for healthcare needs. With that migration to other communities travels revenue from sales tax for meals, gas, shopping and a half day of work. If 10% of the community (2145 citizens) were to utilize healthcare services locally $100,035 in gas and meals alone would remain in the community. Over 20 years, $2,000,700 would be generated from travel. Further, we calculated the revenue lost by patients leaving their jobs for a half day to travel outside the community for healthcare. If 10,000 workers with the average salary of $40,000 took a half day of personal time for doctors appointments outside the area, their absence would generate a loss to industry in the amount of $76,923 in one year and $1,538,461 over 20 years. Further, the revenue generated by local healthcare services would

---

have a significant economic impact on tax valuation. With positive tax revenue, tax rates could be lowered resulting in incentives for business and industry to develop in the area. Job creation, housing expansion and development of amenities add to the quality of life for Calhoun County residents.

In July 2012, Formosa Plastics Corporation and Calhoun County agreed to a $2 million tax abatement for future plant expansions. Recognizing the need for access to healthcare, Formosa Plastics designated the funds be used for construction of a Hospital Based Clinic. To industry, the need for access to healthcare locally is valued more than $2 million.

Secondly, we subjectively valued the quality of life associated with the convenience of local healthcare. In determining the value, we took into consideration the value of a coordinated home health model for patient outcomes\(^2\), and the value of support groups to patient recovery. Redford Williams, Director, Behavioral Medicine Research Center at Duke noted, "Back in 1992 we published a paper in JAMA that clearly documented this (importance of support), showing that heart patients with a spouse, a confidant or both had a 5-year mortality rate of only 18 percent, compared to only 50 percent in those with neither spouse nor confidant." Having access to care at home, lends to a “social recovery model” with the convenience of family and friends assisting in the support group towards recovery. We estimate the value of a coordinated care model with the added convenience of a “social recovery model” as $25,000 per person. We attribute the value to wages earned by patient, supporting members and shorter recovery periods. If 100 patients experienced the benefits of quality of life per year, the value would be $2,500,000. Over 20 years, the quality of life would be valued at $50,000,000.

In a recent assessment conducted by iVantage, they concluded that Medicare costs per capita dollar by Physician service type were $531 more expensive in urban areas than rural\(^3\). In one year, if 2154 (10% of the County) Medicare patients from Calhoun County received their Physician services locally rather than urban areas, Medicare would save $1,139,207. Over the course of twenty years, Medicare would save $22,784,148 in Physician services.

In closing, the access to primary and specialty healthcare through a hospital based clinic is valued at $5,816,165 for year one of the Waiver. For the lifetime of the Waiver 1115, the value of these projects to rural Calhoun County, Texas is valued at $17,264,660.


\(^3\)iVantage, *Rural Relevance Under Healthcare Reform*, April 2012.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>137909111.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be determined</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project Planning</td>
<td><strong>Process Milestone 2 [P-2]:</strong> Establish baseline rates</td>
</tr>
<tr>
<td>Metric: Develop plan for conducting CAHPS survey and contract with vendor for implementation</td>
<td>Data Source: CAHPS data from surveys to develop baseline on customer satisfaction with timely care, appointments, and information.</td>
</tr>
<tr>
<td>Data Source: Vendor contract and customized CAHPS surveys developed by vendor.</td>
<td>Process Milestone 2 Estimated Incentive Payment: $18,175</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $31,359</td>
<td><strong>Process Milestone 3 [P-3]:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
</tr>
<tr>
<td></td>
<td>Data Source: CAHPS data and vendor reports; Minutes for stakeholder meetings</td>
</tr>
<tr>
<td></td>
<td>Process Milestone 3 Estimated Incentive Payment: $18,175</td>
</tr>
<tr>
<td></td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $36,349</td>
</tr>
<tr>
<td></td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $139,479</td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): IT-9.2 Right Care, Right Setting

Performing Provider/TPI: Memorial Medical Center/137909111
Unique RHP outcome identification number: 137909111.3.5

Project Description:
To increase the ability of Memorial Medical Center (MMC) to provide the “right care at the right time in the right setting,” proper utilization of Emergency Department will be directed with expanded primary and specialty care access through the establishment of a hospital-based clinic. This “expanding access to care” initiative will provide critically needed services to a medically underserved area of rural Texas as identified in our Region’s community needs assessment.

Currently, we have 38% non-emergent visits in our ED annually. This is a priority project for our organization to alleviate the high cost of non-urgent visits. In order to provide preventive and primary care, we must first have the capacity to expand access for patients to these services. With the addition of a hospital-based clinic, we will be able to provide an alternative care setting and avoid more costly ER and inpatient care. Engaging patients in preventive and primary care will also provide care management which yields more healthy outcomes and reduces the cost burden on public payers, which represents 54% of our total payer mix.

Outcome Measure Description:
To progressively measure and implement appropriate changes, specific steps and milestones are integrated into Memorial Medical’s Center Access to Care four year plan. Following is synopsis of the selected milestones and associated metrics.

a. Numerator: The number of individuals admitted to Emergency Department with non-emergent condition before established Hospital Based Clinic.
b. Denominator: The number of individuals admitted to Emergency Department with non-emergent condition after Hospital Based Clinic is operational.

During DY2, when the infrastructure for a Hospital Based Clinic is under development, MMC shall assemble all stakeholders and analyze the utilization of the Emergency Department for non-emergent conditions. ED registration and logs shall be the main source of information for this measure. This process milestone is valued at $31,349 to identify current capacity and needed resources, determine timelines and document implementation plans.

For demonstration year 3, we will establish the baseline. Milestone 2 includes collecting the data from encounters, claims data, ER visit records/logs. We value milestone two at $36,349 for staffing, analysis, and monitoring. Milestone 3 launches a critical step to any successful program, disseminate findings and establish lessons learned and best practices with stakeholders.

In DY4, MMC shall incorporate the milestones in DY3 to produce targeted improvement outcomes in this project year. By redirecting non-emergent cases to the Hospital Based Clinic (which offers extended hours and days of service), we shall see changes to the ED appropriate utilization. The result shall be a reduction in all ED visits (including ACSC). We value this milestone at $58,327 including staffing, analyzing, and cost savings.

Finally, in DY5, with positive patient experience at the Hospital Based Clinic and proper utilization of the Emergency Department, we should experience a decrease in ED use for non-emergent conditions. We value this DSRIP milestone at $139,478 including staffing, analyzing, redirection, and establishing a coordinated care model. In Year 4 we expect to see a 5% reduction over Baseline rates (established in Year 2). In Year 5 we expect to see a 10%
reduction over baseline rates. These reductions would demonstrate incremental progress toward meeting individuals’ needs in settings other than the ED.

**Rationale:**
Our primary goal is to promote more patient-centered care focus on community wellness and enhanced coordination of care. With expanded access to care through a Hospital Based Clinic and a dedication to patient satisfaction, Memorial Medical Center’s project development shall be a multi-year transformational effort as an innovative way to deliver care. By providing the right care at the right time and in the right setting, over time, patients in Calhoun County will hopefully see their overall health improve, rely less on costly ED visits and incur fewer avoidable hospital stays.

The rationale for selecting these process milestones and outcome is to demonstrate if access to healthcare services and appropriate redirection can effectively impact inappropriate ED utilization in a short period of time. One of the main concerns raised in Memorial Medical Center’s assessment is that even when patients have public healthcare coverage (Medicaid, Medicare, or indigent healthcare coverage), these patients still cannot identify a usual source of care other than the ED or will continue to use the ED for potentially preventable and/or non-emergent conditions. We attribute this challenge to the lack of access to primary care physicians.

Appropriate ED utilization is a measure of health needs being met at appropriate levels of care. Some ED visits are necessary. Others occur because of lack of convenient access to other levels of care or exacerbation of illnesses thought to be manageable through high quality ambulatory care. We chose this outcome because we expect increased access to primary care through our Category 1 project to reduce utilization of ED services. Expanded primary care is expected to reduce the need for ED services in this non-emergent group. The presumption is that reduction of all cause admissions will capture reductions in visits for ambulatory care sensitive conditions that may be better handled in the primary care setting and reduction of visits for non-urgent or non-emergent reasons that may also be better-handled in a primary care setting when sufficient access to primary care is available.

Because over 60% of our community out-migrates for healthcare needs, it is important that patient satisfaction and access to care needs are met locally. Lack of access to healthcare has overburdened our Emergency Department to act as a Clinic. The results are delay in care, non-managed follow up care, and high costs. Our participation in a collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

**Outcome Measure Valuation:**
The creation of the Hospital Based Clinic will create a stronger health focused link to the general public of the county ultimately decreasing the number of inpatient and outpatient visits to the hospital facility and increase the care given by a direct provider. Redirecting to proper utilization of the Emergency Department will lend to cost savings for the patient, community and associated stakeholders.

---

When valuing the expansion of access to both primary and specialty care in Calhoun County, we looked at the project three-fold. We found such a project had significant economic, quality of life and cost savings value.

First, we surmised the economic value to the County as a whole, the patient, and industry. Roughly 70% of Calhoun County out-migrates for healthcare needs. With that migration to other communities travels revenue from sales tax for meals, gas, shopping and a half day of work. If 10% of the community (2145 citizens) were to utilize healthcare services locally $100,035 in gas and meals alone would remain in the community. Over 20 years, $2,000,700 would be generated from travel. Further, we calculated the revenue lost by patients leaving their jobs for a half day to travel outside the community for healthcare. If 10,000 workers with the average salary of $40,000 took a half day of personal time for doctors appointments outside the area, their absence would generate a loss to industry in the amount of $76,923 in one year and $1,538,461 over 20 years. Further, the revenue generated by local healthcare services would have a significant economic impact on tax valuation. With positive tax revenue, tax rates could be lowered resulting in incentives for business and industry to develop in the area. Job creation, housing expansion and development of amenities add to the quality of life for Calhoun County residents.

In July 2012, Formosa Plastics Corporation and Calhoun County agreed to a $2 million tax abatement for future plant expansions. Recognizing the need for access to healthcare, Formosa Plastics designated the funds be used for construction of a Hospital Based Clinic. To industry, the need for access to healthcare locally is valued more than $2 million.

Secondly, we subjectively valued the quality of life associated with the convenience of local healthcare. In determining the value, we took into consideration the value of a coordinated home health model for patient outcomes, and the value of support groups to patient recovery. Redford Williams, Director, Behavioral Medicine Research Center at Duke noted, "Back in 1992 we published a paper in JAMA that clearly documented this (importance of support), showing that heart patients with a spouse, a confidant or both had a 5-year mortality rate of only 18 percent, compared to only 50 percent in those with neither spouse nor confidant." Having access to care at home, lends to a “social recovery model” with the convenience of family and friends assisting in the support group towards recovery. We estimate the value of a coordinated care model with the added convenience of a “social recovery model” as $25,000 per person. We attribute the value to wages earned by patient, supporting members and shorter recovery periods. If 100 patients experienced the benefits of quality of life per year, the value would be $2,500,000. Over 20 years, the quality of life would be valued at $50,000,000.

In a recent assessment conducted by iVantage, they concluded that Medicare costs per capita dollar by Physician service type were $531 more expensive in urban areas than rural. In one year, if 2154 (10% of the County) Medicare patients from Calhoun County received their Physician services locally rather than urban areas, Medicare would save $1,139,207. Over the course of twenty years, Medicare would save $22,784,148 in Physician services.

In closing, the access to primary and specialty healthcare through a hospital based clinic is valued at $5,816,165 for year one of the Waiver. For the lifetime of the Waiver 1115, the value of these projects to rural Calhoun County, Texas is valued at $17,264,660. In addition, the

---

3 iVantage, Rural Relevance Under Healthcare Reform, April 2012.
cost savings for proper utilization of the Emergency Department adds another layer of value as a direct result to having access to healthcare.
<table>
<thead>
<tr>
<th>137909111.3.5</th>
<th>3.IT.9.2</th>
<th>Right Care, Right Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Memorial Medical Center</td>
<td>137909111</td>
</tr>
<tr>
<td><strong>Related Category 1 or 2 Projects:</strong></td>
<td>137909111.1.1</td>
<td></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>To be determined</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 2 [P-2]:</strong> Establish baseline rates</td>
<td><strong>Outcome Improvement Target 1 [IT-9.2]:</strong> ED appropriate utilization- Reduce all ED visits (including ACSC)</td>
</tr>
<tr>
<td>Data Source: Project Plan</td>
<td>Metric TBD Data Source: Encounter / claims data, ER visit records/logs.</td>
<td>Improvement Target: Reduce 150 visits from baseline. Data Source: Encounter / claims data, ER visit records/logs</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (<em>maximum amount</em>): $ 31,359</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 36,349</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $58,328</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> (add incentive payments amounts from each milestone/outcome improvement target): $ 31,359</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $ 36,349</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $ 58,328</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (*add outcome amounts over D1ys 2-5*): $ 265,514
Memorial Medical Center
Pass 2
Title of Outcome Measure (Improvement Target): IT-5.1- Improved cost savings: Demonstrate cost savings in care delivery

Performing Provider/TPI: Memorial Medical Center/137909111
Unique RHP outcome identification number: 137909111.3.2

Project Description:
OD-5 Cost of Care – IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery
A Medication Dispensing System will decrease costs through efficiencies gained with automation (labeling, dispensing, tracking, etc.) thus decreasing labor costs. Therefore, we will measure the decreasing average labor cost per prescription as the percentage of total prescriptions processed through automation increases.
   a) We will implement cost accounting systems to measure intervention impacts by monitoring average labor cost per prescription.
   b) We will establish a method to measure cost containment by using the total salaries and benefits (as the numerator) and total number of automated prescriptions filled (as the denominator) as stated on the monthly operating statements.
   c) We will use the current state from the month preceding implementation as our baseline for cost. We currently have no automation.
   d) We will measure cost containment by comparing the project’s average labor cost per prescription and the percentage of automated prescriptions filled to the baseline at yearly intervals.
This cost savings is based on the current volume of 120,000 prescriptions per year.

Outcome Measure Description:
Process Milestones:
DY2: P-2 Establish a baseline rate

Improvement Milestones:
DY3-DY5: IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (stand-alone)

Outcome Improvement Targets:
DY3: Cost savings: 7% decrease in average labor cost per prescription when processing 20% of the total automated prescription volume by the end of the year.
DY4: Cost savings: 19% decrease in average labor cost per prescription over established baseline by processing 90% of the total automated prescription volume.
DY5: Cost savings: 31% decrease in average labor cost per prescription over established baseline by continuing to process 90% of the total automated prescription volume.

Rationale:
Our process milestone P-2 is to establish a baseline cost based on current state before implementation of automated medication dispensing.

Outcome Improvements will be analyzed by the Cost Benefit Analysis comparing the average labor cost per prescription at the goal percentage rates compared to baseline average labor cost per prescription. Considering that there is no current automation at Memorial Medical Center’s Pharmacy for prescription processing, the baseline rate will be the average labor cost per prescription
when 0% of prescriptions are filled with the help of automation. The data source will be the monthly operating statement from the month prior to go-live.

In DY3 cost savings result from a 7% decrease the average labor cost per prescription using the total salaries and benefits/total number of MMC automated prescriptions as found on the monthly operating statement compared to baseline. The cost savings are a result of automation efficiencies.

In DY4, cost savings result from a 19% decrease from baseline in the average labor cost per prescription using the total salaries and benefits/total number of MMC automated prescriptions as found on the monthly operating statement compared to baseline. The cost savings are a result of automation efficiencies.

In DY5, cost savings result from a 31% decrease from baseline in the average labor cost per prescription using the total salaries and benefits/total number of MMC automated prescriptions as found on the monthly operating statement compared to baseline. The cost savings are a result of automation efficiencies.

**Outcome Measure Valuation:** This project is a supporting pillar for one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in Calhoun County. The value of the project is based on cost avoidance, projecting savings associated with reducing the costs incurred in filling 120,000 current patient prescriptions on an annual basis. Based on the increase in primary care volumes addressed in another Memorial Medical Center Waiver project, further growth in volume is projected. Despite this increase in prescription volume, processing costs are projected to decrease in total with the addition of a medication dispensing system. The prompt availability of needed prescriptions for our underserved patients, particularly those with chronic disease that can be managed effectively with appropriate pharmaceuticals, will result in fewer emergency room visits, and will also help to prevent future downstream inpatient admissions.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-2]: Establish a baseline for cost Metric 1 [P-2.1]: Average labor cost per prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal: Provide documentation of the updated baseline average cost/Rx</td>
</tr>
<tr>
<td>Data Source: Operating statements from the month immediately preceding implementation of automated medication dispensing.</td>
</tr>
<tr>
<td>Milestone 1 Estimated Incentive Payment (maximum amount): $9,716</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome Improvement Target 1 [IT-5.1]: Improved cost savings: Demonstrate cost savings in care delivery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of analysis: Cost Benefit Analysis using average labor cost per prescription calculated by total salaries and benefits divided by total # of prescriptions distributed through medication dispensing units</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement Target: Decrease average labor cost per prescription 7% from established baseline (based on 120,000 annual prescription volume)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data source: Monthly operating statements – Total Salaries &amp; Benefits and Prescription Statistics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $11,510</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Outcome Improvement Target 2 [IT-5.1]: Improved cost savings: Demonstrate cost savings in care delivery |
| Type of analysis: Cost Benefit Analysis using average labor cost per prescription calculated by total salaries and benefits divided by total # of prescriptions distributed through medication dispensing units |
| Improvement Target: Decrease average labor cost per prescription 19% from baseline (based on 120,000 annual prescription volume) |
| Data source: Monthly operating statements – Total Salaries & Benefits and Prescription Statistics |
| Outcome Improvement Target 2 Estimated Incentive Payment: $18,684 |

| Outcome Improvement Target 3 [IT-5.1]: Improved cost savings: Demonstrate cost savings in care delivery |
| Type of analysis: Cost Benefit Analysis using average labor cost per prescription calculated by total salaries and benefits divided by total # of prescriptions distributed through medication dispensing units |
| Improvement Target: Decrease average labor cost per prescription 31% from baseline (based on 120,000 annual prescription volume) |
| Data source: Monthly operating statements – Total Salaries & Benefits and Prescription Statistics |
| Outcome Improvement Target 3 Estimated Incentive Payment: $44,520 |

| Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 9,716 |
| Year 3 Estimated Outcome Amount: $ 11,510 |
| Year 4 Estimated Outcome Amount: $ 18,684 |
| Year 5 Estimated Outcome Amount: $ 44,520 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5); $84,430
Memorial Medical Center
Pass 3
Title of Outcome Measure (Improvement Target): IT-6.1 Patient Satisfaction
Performing Provider/TPI: Memorial Medical Center/137909111
Unique RHP outcome identification number: 137909111.3.3/Pass 3

Outcome Measure Description:
To increase the ability of Memorial Medical Center (MMC) to provide the “right care at the right time in the right setting,” patient satisfaction with primary, specialty care, and hospital services shall be essential. With the “expanding access to care” initiative (137909111.1.1) we will provide critically needed services to a medically underserved area of rural Texas as identified in our Region’s community needs assessment. However, ensuring patients have access to services at times that are convenient for them, are able to secure appointments with appropriate providers, (therefore reducing the inappropriate use of the hospital emergency department for non-urgent and primary care service) are critical elements to producing life saving, as well as, cost saving measures. Having fully trained staff to successfully create a patient friendly coordinated care model is essential.

Since this is a new project for Memorial Medical Center, we will use DY 2 & DY 3 to plan the project and establish baseline rates. In DY 4 & DY 5, we will measure IT-6.1 Percent improvement over baseline of patient satisfaction scores specifically related to the measure IT-6.1.1 Patients are getting timely care, appointments, and information. Currently, a structured patient satisfaction survey does not exist to capture this measure at Memorial Medical Center. Therefore, the baseline will be set at 0. However, we expect to improve this measure by 5% by the end of the waiver.

Rationale:
Memorial Medical Center has selected the process milestones and outcome improvement targets because we are certain if the patient receives timely healthcare and education, they are more likely to continue leading healthy lives and obtaining preventive healthcare on a regular basis which ultimately leads to reduced healthcare costs.

We intend to use the CG-CAHPS survey to improve our performance as measured by whether patients are (1) getting timely care, appointments and information. Obtaining patient feedback on our ability to provide the right care at the right time is critical to the success of this project and the internal operations of the clinic. This data will provide us with meaningful and objective information that will be used to determine whether our clinic has met patient expectations related to obtaining timely care and information, and will identify areas where we need to improve. Because the community we serve has an insufficient number of providers and patients are often unable to obtain appointments in a timely manner, the priority goal for this project is ensuring patients receive care when they need it and without significant delays, which will result in improved health outcomes and patient satisfaction. Further, with an educated and confident staff, we anticipate better communication between patients and caregivers resulting in positive outcomes and experiences. The CG-CAHPS survey is an effective tool for measuring our progress and will provide valuable information and feedback on our performance and areas where improvement is needed.

Because over 60% of our community out-migrates for healthcare needs, it is important that patient satisfaction and access to care needs are met locally.\(^1\) Measuring that we are meeting

\(^1\)BR Healthcare Services, Inc., Memorial Medical Center Market & Service Area Development Report, October, 2010.
the needs of the patients we intend to serve, represents the best outcome for our project. Through survey results and our participation in a collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

**Outcome Measure Valuation:**
We considered both the costs and benefits to our organization and community in order to value the Outcome Measure – IT-6.1 Percent improvement over baseline of patient satisfaction scores. We believe it will take DY2 and DY3 to effectively develop and plan the Outcome Improvement Targets in DY4 and DY5. We do not currently perform or contract with a company to perform surveys for outpatient services, but we intend to select a vendor in DY 2. We believe with the improvement in patient satisfaction scores specifically the improvement target of patients getting timely care, appointments and information, this will decrease unnecessary Emergency Room visits, hospital stays, etc. because patients will be receiving the care and attention they need on a consistent and dependable basis. This Outcome Measure will serve the total outpatient service population of Memorial Medical Center, and it will ultimately assist Port Lavaca and the surrounding communities to live healthier lives and be healthier communities.

When valuing patient satisfaction with healthcare we looked at the project three-fold. We found such a project had significant economic, quality of life and cost savings value.

First, we surmised the economic value to the County as a whole, the patient, and industry. Roughly 70% of Calhoun County out-migrates for healthcare needs. With that migration to other communities travels revenue from sales tax for meals, gas, shopping and a half day of work. If 10% of the community (2145 citizens) were to utilize healthcare services locally $100,035 in gas and meals alone would remain in the community. Over 20 years, $2,000,700 would be generated from travel. Further, we calculated the revenue lost by patients leaving their jobs for a half day to travel outside the community for healthcare. If 10,000 workers with the average salary of $40,000 took a half day of personal time for doctors appointments outside the area, their absence would generate a loss to industry in the amount of $76,923 in one year and $1,538,461 over 20 years. Further, the revenue generated by local healthcare services would have a significant economic impact on tax valuation. With positive tax revenue, tax rates could be lowered resulting in incentives for business and industry to develop in the area. Job creation, housing expansion and development of amenities add to the quality of life for Calhoun County residents. If we improved access to care and patient satisfaction, the need to leave the area for healthcare services would decrease significantly.

In July 2012, Formosa Plastics Corporation and Calhoun County agreed to a $2 million tax abatement for future plant expansions. Recognizing the need for access to healthcare, Formosa Plastics designated the funds be used for construction of a Hospital Based Clinic. To industry, the need for access to healthcare locally is valued more than $2 million. To the worker, the patient experience must be positive to build trust and healthcare relationships in the area.

Secondly, we subjectively valued the quality of life associated with the convenience of local healthcare. In determining the value, we took into consideration the value of a coordinated home health model for patient outcomes, and the value of support groups to patient recovery. Redford Williams, Director, Behavioral Medicine Research Center at Duke noted, "Back in 1992 we published a paper in JAMA that clearly documented this (importance of support), showing that heart patients with a spouse, a confidant or both had a 5-year mortality rate of only 18

---

percent, compared to only 50 percent in those with neither spouse nor confidant." Having access to care at home, lends to a “social recovery model” with the convenience of family and friends assisting in the support group towards recovery. We estimate the value of a coordinated care model with the added convenience of a “social recovery model” as $25,000 per person. We attribute the value to wages earned by patient, supporting members and shorter recovery periods. If 100 patients experienced the benefits of quality of life per year, the value would be $2,500,000. Over 20 years, the quality of life would be valued at $50,000,000.

In a recent assessment conducted by iVantage, they concluded that Medicare costs per capita dollar by Physician service type were $531 more expensive in urban areas than rural. In one year, if 2154 (10% of the County) Medicare patients from Calhoun County received their Physician services locally rather than urban areas, Medicare would save $1,139,207. Over the course of twenty years, Medicare would save $22,784,148 in Physician services.

In closing, positive patient experiences and access to primary and specialty healthcare is valued at $5,816,165 for year one of the Waiver. For the lifetime of the Waiver 1115, the value of these projects to rural Calhoun County, Texas is valued at $17,264,660. The essential component to achieving these desired outcomes is a trained workforce. The Aidet Project through the Waiver 1115 offers a conduit for this knowledge and transformation.

---

### Improving the Patient Experience – The Aidet Project

**Memorial Medical Center**

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>137909111.2.2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>To be determined</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong></td>
<td><strong>Process Milestone 2 [P-4]:</strong></td>
<td>**Outcome Improvement Target 1</td>
<td><strong>Outcome Improvement Target 2</strong></td>
</tr>
<tr>
<td>Project Planning – identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Establish baseline rates</td>
<td>[IT-6.1(1)]: Percent improvement over baseline of patient satisfaction scores – TBD.</td>
<td>[IT-6.1(1)]: Percent improvement over baseline of patient satisfaction scores – TBD.</td>
</tr>
<tr>
<td>Data Source: Meeting minutes, agenda and plan</td>
<td>Data Source: Meeting minutes, agenda and plan</td>
<td>Improvement Target: Increase patient satisfaction scores for measure 1: Patient is getting timely care, appointments, and information. Data Source: Patient Survey</td>
<td>Improvement Target: Additional increase of patient satisfaction scores for measure 1: Patient is getting timely care, appointments, and information. Data Source: Patient Survey</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment <em>(maximum amount)</em>: $15710</td>
<td>Process Milestone 2 Estimated Incentive Payment: $18825</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $30858</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $73458</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Outcome Amount:** (add incentive payments amounts from each milestone/outcome improvement target): $15710

Year 3 Estimated Outcome Amount: $18825

**Year 4 Estimated Outcome Amount:** $30858

**Year 5 Estimated Outcome Amount:** $73458

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5)*: $138,851
Title of Outcome Measure (Improvement Target): IT-6.1 Patient Satisfaction
Performing Provider/TPI: Memorial Medical Center/137909111
Unique RHP outcome identification number: 137909111.3.4/Pass 3

Outcome Measure Description:
To increase the ability of Memorial Medical Center (MMC) to provide the “right care at the right time in the right setting,” patient satisfaction with primary, specialty care, and hospital services shall be essential. With the “expanding access to care” and Hospitalist initiatives (137909111.1.1 and 137909111.2.3) we will provide critically needed services to a medically underserved area of rural Texas as identified in our Region’s community needs assessment. However, ensuring patients have access to services at times that are convenient for them, are able to secure appointments/access with appropriate caregivers, are critical elements to producing life saving, as well as, cost saving measures.

Since this is a new project for Memorial Medical Center, we will use DY 2 to plan the project and establish baseline rates. In DY3, DY 4 & DY 5, we will measure IT-6.1 Percent improvement over baseline of patient satisfaction scores specifically related to the measure IT-6.1. Patients are getting timely care, appointments, and information. Currently, a structured patient satisfaction survey does not exist to capture this measure at Memorial Medical Center. Therefore, the baseline will be set at 0. However, we expect to improve this measure by 10% by the end of the waiver.

Rationale:
Memorial Medical Center has selected the process milestones and outcome improvement targets because we are certain if the patient receives timely healthcare and education, they are more likely to continue leading healthy lives and obtaining preventive healthcare on a regular basis which ultimately leads to reduced healthcare costs.

We intend to use the HCAHPS survey to improve our performance as measured by whether patients are (1) getting timely care, appointments and information. Obtaining patient feedback on our ability to provide the right care at the right time is critical to the success of this project and the internal operations of the clinic. This data will provide us with meaningful and objective information that will be used to determine whether our clinic has met patient expectations related to obtaining timely care and information, and will identify areas where we need to improve. Because the community we serve has an insufficient number of providers and patients are often unable to obtain appointments in a timely manner or have physicians readily available for hospital admissions. The priority goal for this project is ensuring patients receive care when they need it and without significant delays, which will result in improved health outcomes and patient satisfaction. Further, with an educated and confident staff, we anticipate better communication between patients and caregivers resulting in positive outcomes and experiences. The HCAHPS survey is an effective tool for measuring our progress and will provide valuable information and feedback on our performance and areas where improvement is needed.

Because over 60% of our community out-migrates for healthcare needs, it is important that patient satisfaction and access to care needs are met locally.1 Measuring that we are meeting the needs of the patients we intend to serve, represents the best outcome for our project.

Through survey results and our participation in a collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

**Outcome Measure Valuation:**

We considered both the costs and benefits to our organization and community in order to value the Outcome Measure – IT-6.1 Percent improvement over baseline of patient satisfaction scores. We believe it will take DY2 and part of DY3 to effectively develop and plan the Outcome Improvement Targets in DY4 and DY5. We do not currently perform or contract with a company to perform surveys for outpatient services, but we intend to select a vendor in DY 2. We believe with the improvement in patient satisfaction scores specifically the improvement target of patients getting timely care, appointments and information, this will decrease unnecessary Emergency Room visits, hospital stays, etc. because patients will be receiving the care and attention they need on a consistent and dependable basis. This Outcome Measure will serve the total outpatient service population of Memorial Medical Center, and it will ultimately assist Port Lavaca and the surrounding communities to live healthier lives and be healthier communities.

When valuing patient satisfaction with healthcare we looked at the project three-fold. We found such a project had significant economic, quality of life and cost savings value.

First, we surmised the economic value to the County as a whole, the patient, and industry. Roughly 70% of Calhoun County out-migrates for healthcare needs. With that migration to other communities travels revenue from sales tax for meals, gas, shopping and a half day of work. If 10% of the community (2145 citizens) were to utilize healthcare services locally $100,035 in gas and meals alone would remain in the community. Over 20 years, $2,000,700 would be generated from travel. Further, we calculated the revenue lost by patients leaving their jobs for a half day to travel outside the community for healthcare. If 10,000 workers with the average salary of $40,000 took a half day of personal time for doctors appointments outside the area, their absence would generate a loss to industry in the amount of $76,923 in one year and $1,538,461 over 20 years. Further, the revenue generated by local healthcare services would have a significant economic impact on tax valuation. With positive tax revenue, tax rates could be lowered resulting in incentives for business and industry to develop in the area. Job creation, housing expansion and development of amenities add to the quality of life for Calhoun County residents. If we improved access to care and patient satisfaction, the need to leave the area for healthcare services would decrease significantly. Without consist access to an admitting physician, EMS often bypasses Memorial Medical Center to hospitals outside the service area with physicians onsite. The additional transportation time/cost and inconvenience to patients and their families offers a value to this project as well.

In July 2012, Formosa Plastics Corporation and Calhoun County agreed to a $2 million tax abatement for future plant expansions. Recognizing the need for access to healthcare, Formosa Plastics designated the funds be used for construction of a Hospital Based Clinic. To industry, the need for access to healthcare locally is valued more than $2 million. To the worker, the patient experience must be positive to build trust and healthcare relationships in the area.

Secondly, we subjectively valued the quality of life associated with the convenience of local healthcare. In determining the value, we took into consideration the value of a coordinated home health model for patient outcomes, and the value of support groups to patient recovery.

---

Redford Williams, Director, Behavioral Medicine Research Center at Duke noted, "Back in 1992 we published a paper in JAMA that clearly documented this (importance of support), showing that heart patients with a spouse, a confidant or both had a 5-year mortality rate of only 18 percent, compared to only 50 percent in those with neither spouse nor confidant." Having access to care at home, lends to a “social recovery model” with the convenience of family and friends assisting in the support group towards recovery. We estimate the value of a coordinated care model with the added convenience of a “social recovery model” as $25,000 per person. We attribute the value to wages earned by patient, supporting members and shorter recovery periods. If 100 patients experienced the benefits of quality of life per year, the value would be $2,500,000. Over 20 years, the quality of life would be valued at $50,000,000.

In a recent assessment conducted by iVantage, they concluded that Medicare costs per capita dollar by Physician service type were $531 more expensive in urban areas than rural. In one year, if 2154 (10% of the County) Medicare patients from Calhoun County received their Physician services locally rather than urban areas, Medicare would save $1,139,207. Over the course of twenty years, Medicare would save $22,784,148 in Physician services. In closing, positive patient experiences and access to primary, specialty healthcare in or out of a hospital setting are valued at $5,816,165 for year one of the Waiver. For the lifetime of the Waiver 1115, the value of these projects to rural Calhoun County, Texas is valued at $17,264,660.

---

3iVantage, Rural Relevance Under Healthcare Reform, April 2012.
<table>
<thead>
<tr>
<th>137909111.3.4</th>
<th>IT-6.1</th>
<th>Improved cost savings: Demonstrate cost savings in care delivery (stand alone)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Memorial Medical Center</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>137909111.2.3</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be determined</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-1]</strong>: Project Planning – identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td><strong>Process Milestone 2 [P-4]</strong>: Establish baseline rates</td>
<td><strong>Outcome Improvement Target 1 [IT-6.1]</strong>: Percent improvement over baseline of patient satisfaction scores – TBD.</td>
</tr>
<tr>
<td>Data Source: Meeting minutes, agenda and plan</td>
<td>Data Source: Meeting minutes, agenda and plan</td>
<td>Improvement Target: Increase patient satisfaction scores for measure 1) Patient is getting timely care, appointments, and information. Data Source: Patient Survey: HCAHPS</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (<em>maximum amount</em>): $33024</td>
<td>Process Milestone 2 Estimated Incentive Payment: $39573</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $64866</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $33,024</td>
<td>Year 3 Estimated Outcome Amount: $39,573</td>
<td>Year 4 Estimated Outcome Amount: $64,866</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (*add outcome amounts over DYs 2-5)*: $291,880
Mental Health and Mental Retardation Authority of Harris County
Pass 1
Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Unique RHP outcome identification numbers: 113180703.3.1

Outcome Measure Description:
IT-6.1: Percent improvement over baseline of patient satisfaction scores
- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5% over baseline scores for the communication with provider domain as measured by the CAPHS survey
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10% over baseline scores for the communication with provider domain as measured by the CAPHS survey

Rationale:
The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the
particular program population, we will be more accurate in our assessment of the target outcome. This initiative will permit MHMRA, the performing provider, to improve on previous efforts to measure patient experience, through selection of reliable, valid measures with external benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain of “How Well their Doctors Communicate” by DY2.

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Both the Adult Visit Survey and the Adult Twelve Month Survey versions of the CAHPS questionnaire will be employed. Every new patient referred for outpatient services will receive the Adult Visit Survey after the completion of their first outpatient visit then the Adult Twelve Month Survey version will be used yearly for ongoing patients.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>113180703.3.1</th>
<th>IT-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHMRA of Harris County</td>
<td>113180703</td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 1 or 2:</strong></td>
<td>113180703.1.1</td>
<td></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>Baseline will be collected in DY3 from the 250 patients expected to be served that DY</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1: P-1:</strong> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 6: P-1:</strong> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 11: OD-6:</strong> Patient Satisfaction</td>
<td><strong>Milestone 12: OD-6:</strong> Patient Satisfaction</td>
</tr>
<tr>
<td><strong>Metric 1:</strong> Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td><strong>Metric 6:</strong> Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td><strong>Metric 11: IT 6-1</strong> Percent improvement over baseline of patient satisfaction scores</td>
<td><strong>Metric 12: IT 6-1</strong> Percent improvement over baseline of patient satisfaction scores</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td><strong>Goal:</strong> To complete project planning process and implement</td>
<td><strong>Goal:</strong> 5% increase over baseline</td>
</tr>
<tr>
<td><strong>Goal:</strong> To integrate stakeholder input in development of program plan</td>
<td><strong>Goal:</strong></td>
<td></td>
<td><strong>Goal:</strong> 10% increase over baseline</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Estimated Incentive Payment:</strong></th>
<th><strong>Estimated Incentive Payment:</strong></th>
<th><strong>Estimated Incentive Payment:</strong></th>
<th><strong>Estimated Incentive Payment:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,719.30</td>
<td>$36,481.00</td>
<td>$194,919.26</td>
<td>$423,737.53</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 2: P-2:</strong> Establish baseline</td>
<td><strong>Milestone 7: P-2:</strong> Establish baseline</td>
<td><strong>Milestone 11: OD-6:</strong> Patient Satisfaction</td>
<td><strong>Milestone 12: OD-6:</strong> Patient Satisfaction</td>
</tr>
<tr>
<td><strong>Metric 2:</strong> Identify domains of patient satisfaction to be measured</td>
<td><strong>Metric 7:</strong> Select and implement patient satisfaction survey to assess communication with provider (CAPHS)</td>
<td><strong>Metric 11: IT 6-1</strong> Percent improvement over baseline of patient satisfaction scores</td>
<td><strong>Metric 12: IT 6-1</strong> Percent improvement over baseline of patient satisfaction scores</td>
</tr>
<tr>
<td><strong>Data Source:</strong> literature review</td>
<td><strong>Data Source:</strong> Clinical records; monthly management reports</td>
<td>a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain</td>
<td>a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain</td>
</tr>
<tr>
<td><strong>Goal:</strong> determine how baseline will be established for patient satisfaction domain</td>
<td><strong>Goal:</strong> obtain baseline of satisfaction survey from patients receiving service</td>
<td>b. Denominator: Number of patients who were administered the survey</td>
<td>b. Denominator: Number of patients who were administered the survey</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Estimated Incentive Payment:</strong></th>
<th><strong>Estimated Incentive Payment:</strong></th>
<th><strong>Estimated Incentive Payment:</strong></th>
<th><strong>Estimated Incentive Payment:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,719.30</td>
<td>$36,481.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td><strong>Milestone 3: P-3:</strong> Develop and test data systems</td>
<td><strong>Milestone 8: P-3:</strong> Develop and test data systems</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Metric 3:</strong> Review satisfaction measures for use with the target population and their clinical teams</td>
<td><strong>Metric 8:</strong> Review satisfaction measures for use with the target population</td>
<td>Data Source: Project record—summary of reviews</td>
<td>Data Source: Project record—summary of reviews, completed surveys</td>
</tr>
<tr>
<td><strong>Goal:</strong> Identify/modify one instrument to test in Yr. 3</td>
<td><strong>Goal:</strong> Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $15,719.30</td>
<td><strong>Estimated Incentive Payment:</strong> $36,481.00</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Milestone 4: P-4:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td><strong>Milestone 9: P-9:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Metric 4:</strong> Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td><strong>Metric 9:</strong> Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td>Data Source: Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td>Data Source: Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
</tr>
<tr>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be collected in DY3 from the 250 patients expected to be served that DY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong></td>
<td><strong>Estimated Incentive Payment:</strong></td>
<td><strong>Estimated Incentive Payment:</strong></td>
<td><strong>Estimated Incentive Payment:</strong></td>
</tr>
<tr>
<td>$15,719.30</td>
<td>$36,481.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5:</strong> P-5 Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Metric 5:</strong> Report status, progress and lessons learned to stakeholders</td>
<td><strong>Metric 10:</strong> P-5: Disseminate findings to stakeholders</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $78,596.48</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $182,405.01</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $194,919.26</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $423,737.53</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $879,658.28
Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.3

Outcome Measure Description:
IT-6.1: Percent improvement over baseline of patient satisfaction scores
- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5% over baseline scores for the communication with provider domain as measured by the CAPHS survey
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10% over baseline scores for the communication with provider domain as measured by the CAPHS survey

Rationale:
The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. This initiative will permit MHMRA, the performing provider, to improve on previous efforts to measure patient experience, through selection of reliable, valid measures with external
benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain of “How Well their Doctors Communicate” by DY2.

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Both the Adult Visit Survey and the Adult Twelve Month Survey versions of the CAHPS questionnaire will be employed. Every new patient referred for outpatient services will receive the Adult Visit Survey after the completion of their first outpatient visit then the Adult Twelve Month Survey version will be used yearly for ongoing patients.

**Outcome Measure Valuation:**
Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>Related Category 1 or 2:</th>
<th>113180703.1.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be taken in DY 3 with about 150 anticipated patients</td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
</tr>
<tr>
<td><strong>Milestone 1: P-1:</strong> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 6: P-1:</strong> Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
</tr>
<tr>
<td><strong>Metric 1:</strong> Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td><strong>Metric 6:</strong> Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
</tr>
<tr>
<td><strong>Goal:</strong> To integrate stakeholder input in development of program plan</td>
<td><strong>Goal:</strong> To complete project planning process and implement</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $7,990.49</td>
<td><strong>Estimated Incentive Payment:</strong> $18,644.16</td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment: $215,895.89**

**Estimated Incentive Payment:** $99,582.11

**Data Source:** Clinical records; monthly management reports

**Goal:** obtain baseline of satisfaction survey from patients receiving service

**Estimated Incentive Payment:** $18,644.16

**Estimated Incentive Payment:** $18,644.16
<table>
<thead>
<tr>
<th>Related Category 1 or 2:</th>
<th>113180703.1.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be taken in DY 3 with about 150 anticipated patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 3: P-3:** Develop and test data systems  
**Metric 3:** Review satisfaction measures for use with the target population and their clinical teams  
**Data Source:** Project record—summary of reviews  
**Goal:** Identify/modify one instrument to test in Yr. 3

**Milestone 8: P-3:** Develop and test data systems  
**Metric 8:** Review satisfaction measures for use with the target population  
**Data Source:** Project record—summary of reviews, completed surveys  
**Goal:** Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3

**Estimated Incentive Payment:**  
$7,990.49

**Milestone 4: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Metric 4:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles  
**Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement  
**Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations

**Milestone 9: P-9:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Metric 9:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles  
**Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement  
**Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations

**Estimated Incentive Payment:**  
$18,644.16
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $7,990.49</td>
<td><strong>Estimated Incentive Payment:</strong> $18,644.16</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5:</strong> P-5 Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Milestone 10:</strong> P-5: Disseminate findings to stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 5:</strong> Report status, progress and lessons learned to stakeholders</td>
<td><strong>Metric 10:</strong> Report status, progress and lessons learned to stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $7,990.49</td>
<td><strong>Estimated Incentive Payment:</strong> $18,644.16</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $39,952.46</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $93,220.82</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $99,582.11</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $215,895.89</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $448,651.28
Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.4

Outcome Measure Description:
IT-6.1: Percent improvement over baseline of patient satisfaction scores
- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5% over baseline scores for the communication with provider domain as measured by the CAPHS survey
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10% over baseline scores for the communication with provider domain as measured by the CAPHS survey

Rationale:
The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome.
This initiative will permit MHMRA, the performing provider, to improve on previous efforts to measure patient experience, through selection of reliable, valid measures with external benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain of “How Well their Doctors Communicate” by DY2.

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient experience is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Both the Adult Visit Survey and the Adult Twelve Month Survey versions of the CAHPS questionnaire will be employed. Every new patient referred for outpatient services will receive the Adult Visit Survey after the completion of their first outpatient visit then the Adult Twelve Month Survey version will be used yearly for ongoing patients.

**Outcome Measure Valuation:**
Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>Related Category 1 or 2:</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHMRA of Harris County</td>
<td>113180703.3.4</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be collected in DY3 from the 250 patients expected to be served that DY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
**Metric 1:** Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information  
**Data Source:** Meetings minutes, project flow charts and timelines  
**Goal:** To integrate stakeholder input in development of program plan  
**Estimated Incentive Payment:** $5,281.98

**Milestone 2: P-2:** Establish baseline  
**Metric 1:** Identify domains of patient satisfaction to be measured  
**Data Source:** literature review  
**Goal:** determine how baseline will be established for patient satisfaction domain  
**Estimated Incentive Payment:** $5,281.98

**Milestone 3:** Establish baseline  
**Metric 1:** Identify domains of patient satisfaction to be measured  
**Data Source:** Clinical records; monthly management reports  
**Goal:** obtain baseline of satisfaction survey from patients receiving service  
**Estimated Incentive Payment:** $12,258.32

**Milestone 4:** Establish baseline  
**Metric 1:** Identify domains of patient satisfaction to be measured  
**Data Source:** Clinical records; monthly management reports  
**Goal:** obtain baseline of satisfaction survey from patients receiving service  
**Estimated Incentive Payment:** $65,496.61

**Milestone 5:** Establish baseline  
**Metric 1:** Identify domains of patient satisfaction to be measured  
**Data Source:** Clinical records; monthly management reports  
**Goal:** obtain baseline of satisfaction survey from patients receiving service  
**Estimated Incentive Payment:** $142,383.93

**Milestone 6: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
**Metric 1:** Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information  
**Data Source:** Meetings minutes, project flow charts and timelines  
**Goal:** To complete project planning process and implement  
**Estimated Incentive Payment:** $12,258.32

**Milestone 7: P-2:** Establish baseline  
**Metric 1:** Identify domains of patient satisfaction to be measured  
**Data Source:** Clinical records; monthly management reports  
**Goal:** obtain baseline of satisfaction survey from patients receiving service  
**Estimated Incentive Payment:** $65,496.61

**Milestone 8:** Establish baseline  
**Metric 1:** Identify domains of patient satisfaction to be measured  
**Data Source:** Clinical records; monthly management reports  
**Goal:** obtain baseline of satisfaction survey from patients receiving service  
**Estimated Incentive Payment:** $142,383.93

**Milestone 9:** Establish baseline  
**Metric 1:** Identify domains of patient satisfaction to be measured  
**Data Source:** Clinical records; monthly management reports  
**Goal:** obtain baseline of satisfaction survey from patients receiving service  
**Estimated Incentive Payment:** $65,496.61

**Milestone 10:** Establish baseline  
**Metric 1:** Identify domains of patient satisfaction to be measured  
**Data Source:** Clinical records; monthly management reports  
**Goal:** obtain baseline of satisfaction survey from patients receiving service  
**Estimated Incentive Payment:** $142,383.93

**Milestone 11: OD-6:** Patient Satisfaction  
**Metric 1:** IT 6-1 Percent improvement over baseline of patient satisfaction scores  
  a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CPHS domain  
  b. Denominator: Number of patients who were administered the survey  
**Data Source:** Patient survey  
**Goal:** 5% increase over baseline

**Milestone 12: OD-6:** Patient Satisfaction  
**Metric 1:** IT 6-1 Percent improvement over baseline of patient satisfaction scores  
  a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CPHS domain  
  b. Denominator: Number of patients who were administered the survey  
**Data Source:** Patient survey  
**Goal:** 10% increase over baseline
<table>
<thead>
<tr>
<th>Milestone 3: P-3:</th>
<th>Year 2</th>
<th>Milestone 8: P-3:</th>
<th>Year 3</th>
<th>Milestone 4: P-4:</th>
<th>Year 4</th>
<th>Milestone 9: P-9:</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1:</strong> Review satisfaction measures for use with the target population and their clinical teams</td>
<td>(10/1/2012 – 9/30/2013)</td>
<td><strong>Metric 1:</strong> Review satisfaction measures for use with the target population</td>
<td>(10/1/2013 – 9/30/2014)</td>
<td><strong>Metric 4:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>(10/1/2014 – 9/30/2015)</td>
<td><strong>Metric 9:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>(10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project record—summary of reviews</td>
<td><strong>Data Source:</strong> Project record—summary of reviews, completed surveys</td>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> Identify/modify one instrument to test in Yr. 3</td>
<td><strong>Goal:</strong> Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3</td>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td></td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment:** $5,281.98

**Estimated Incentive Payment:** $12,258.32
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $5,281.98</td>
<td><strong>Estimated Incentive Payment:</strong> $12,258.32</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5: P-5</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Metric 10: Report status, progress and lessons learned to stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 5: Report status, progress and lessons learned to stakeholders</strong></td>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $5,281.98</td>
<td><strong>Estimated Incentive Payment:</strong> $12,258.32</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $26,409.92</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $61,291.58</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $65,496.61</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $142,383.93</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $295,582.04
Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

**Unique RHP outcome identification numbers:** 113180703.3.5

**Outcome Measure Description:**

IT-6.1: Percent improvement over baseline of patient satisfaction scores
- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

**Process Milestones:**
- **DY 2:**
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- **DY 3:**
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

**Outcome Improvement Targets for each year:**
- **DY 4:**
  - IT 6.1: Rate 1: Improve patient satisfaction by 5% over baseline scores for the communication with provider domain as measured by the CAPHS survey
- **DY 5:**
  - IT 6.1: Rate 1: Improve patient satisfaction by 10% over baseline scores for the communication with provider domain as measured by the CAPHS survey

**Rationale:**
The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome.
This initiative will permit MHMRA, the performing provider, to improve on previous efforts to measure patient experience, through selection of reliable, valid measures with external benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain of “How Well their Doctors Communicate” by DY2.

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Both the Adult Visit Survey and the Adult Twelve Month Survey versions of the CAHPS questionnaire will be employed. Every new patient referred for outpatient services will receive the Adult Visit Survey after the completion of their first outpatient visit then the Adult Twelve Month Survey version will be used yearly for ongoing patients.

**Outcome Measure Valuation:**
Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>Milestone 1: P-1: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Milestone 6: P-1: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Milestone 11: OD-6: Patient Satisfaction</th>
<th>Milestone 12: OD-6: Patient Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 1:</strong> Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td><strong>Metric 6:</strong> Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td><strong>Metric 11:</strong> IT 6-1 Percent improvement over baseline of patient satisfaction scores</td>
<td><strong>Metric 12:</strong> IT 6-1 Percent improvement over baseline of patient satisfaction scores</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td>a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain</td>
<td>a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain</td>
</tr>
<tr>
<td><strong>Goal:</strong> To integrate stakeholder input in development of program plan</td>
<td><strong>Goal:</strong> To complete project planning process and implement</td>
<td>b. Denominator: Number of patients who were administered the survey</td>
<td>b. Denominator: Number of patients who were administered the survey</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $15,719.30</td>
<td><strong>Estimated Incentive Payment:</strong> $36,481.00</td>
<td><strong>Data Source:</strong> Patient survey</td>
<td><strong>Data Source:</strong> Patient survey</td>
</tr>
<tr>
<td><strong>Metric 2:</strong> Establish baseline</td>
<td><strong>Metric 7:</strong> P-2: Establish baseline</td>
<td><strong>Goal:</strong> 5% increase over baseline</td>
<td><strong>Goal:</strong> 10% increase over baseline</td>
</tr>
<tr>
<td><strong>Metric 2:</strong> Identify domains of patient satisfaction to be measured</td>
<td><strong>Metric 7:</strong> Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> literature review</td>
<td><strong>Data Source:</strong> Clinical records; monthly management reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> determine how baseline will be established for patient satisfaction domain</td>
<td><strong>Goal:</strong> obtain baseline of satisfaction survey from patients receiving service</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $15,719.30</td>
<td><strong>Estimated Incentive Payment:</strong> $36,481.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2:</td>
<td>MHMRA of Harris County</td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------</td>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>$15,719.30</td>
<td>$36,481.00</td>
<td></td>
</tr>
</tbody>
</table>

Baseline will be collected in DY3 from the 250 patients expected to be served that DY

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 3: P-3:** Develop and test data systems
**Metric 3:** Review satisfaction measures for use with the target population and their clinical teams
**Data Source:** Project record—summary of reviews
**Goal:** Identify/modify one instrument to test in Yr. 3

**Milestone 8: P-3:** Develop and test data systems
**Metric 8:** Review satisfaction measures for use with the target population
**Data Source:** Project record—summary of reviews, completed surveys
**Goal:** Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3
<table>
<thead>
<tr>
<th>Milestone 4: P-4</th>
<th>Milestone 9: P-9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</strong></td>
<td><strong>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</strong></td>
</tr>
<tr>
<td><strong>Metric 4: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</strong></td>
<td><strong>Metric 9: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</strong></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
</tr>
<tr>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,719.30</td>
<td>$36,481.00</td>
</tr>
</tbody>
</table>

**Milestone 5: P-5** Disseminate findings, including lessons learned and best practices, to stakeholders

**Metric 5: Report status, progress and lessons learned to stakeholders**

**Data Source:** management team minutes, RHP collaborations

**Goal:** To disseminate information about the project and solicit input from stakeholders

<table>
<thead>
<tr>
<th>Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,719.30</td>
<td>$36,481.00</td>
</tr>
</tbody>
</table>

**Milestone 10: P-5** Disseminate findings to stakeholders

**Metric 10:** Report status, progress and lessons learned to stakeholders

**Data Source:** management team minutes, RHP collaborations

**Goal:** To disseminate information about the project and solicit input from stakeholders
<table>
<thead>
<tr>
<th>Related Category 1 or 2:</th>
<th>113180703.1.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be collected in DY3 from the 250 patients expected to be served that DY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Year 2 Estimated Outcome Amount</th>
<th>Year 3 Estimated Outcome Amount</th>
<th>Year 4 Estimated Outcome Amount</th>
<th>Year 5 Estimated Outcome Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$78,596.48</td>
<td>$182,405.01</td>
<td>$194,919.26</td>
<td>$423,737.53</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $879,658.28
Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.6

Outcome Measure Description:
IT-6.1: Percent improvement over baseline of patient satisfaction scores
- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5% over baseline scores for the communication with provider domain as measured by the CAPHS survey
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10% over baseline scores for the communication with provider domain as measured by the CAPHS survey

Rationale:
The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. This initiative will permit MHMRA, the performing provider, to improve on previous efforts to
measure patient experience, through selection of reliable, valid measures with external benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain of “How Well their Doctors Communicate” by DY2.

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Both the Adult Visit Survey and the Adult Twelve Month Survey versions of the CAHPS questionnaire will be employed. Every new patient referred for outpatient services will receive the Adult Visit Survey after the completion of their first outpatient visit then the Adult Twelve Month Survey version will be used yearly for ongoing patients.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>Related Category 1 or 2:</th>
<th>MHMRA of Harris County</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be collected in DY3 from the 250 patients expected to be served that DY</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Milestone 1: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
**Metric 1:** Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information  
**Data Source:** Meetings minutes, project flow charts and timelines  
**Goal:** To integrate stakeholder input in development of program plan | **Milestone 6: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
**Metric 6:** Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information  
**Data Source:** Meetings minutes, project flow charts and timelines  
**Goal:** To complete project planning process and implement | **Milestone 11: OD-6:** Patient Satisfaction  
**Metric 11:** IT 6-1 Percent improvement over baseline of patient satisfaction scores  
- Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPHs domain  
- Denominator: Number of patients who were administered the survey  
**Data Source:** Patient survey  
**Goal:** 5% increase over baseline | **Milestone 12: OD-6:** Patient Satisfaction  
**Metric 12:** IT 6-1 Percent improvement over baseline of patient satisfaction scores  
- Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPHs domain  
- Denominator: Number of patients who were administered the survey  
**Data Source:** Patient survey  
**Goal:** 10% increase over baseline |

| Estimated Incentive Payment: $15,719.30 | Estimated Incentive Payment: $36,481.00 | Estimated Incentive Payment: $194,919.26 | Estimated Incentive Payment: $423,737.53 |

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Milestone 2: P-2:** Establish baseline  
**Metric 2:** Identify domains of patient satisfaction to be measured  
**Data Source:** literature review  
**Goal:** determine how baseline will be established for patient satisfaction domain | **Milestone 7: P-2:** Establish baseline  
**Metric 7:** Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction  
**Data Source:** Clinical records; monthly management reports  
**Goal:** obtain baseline of satisfaction survey from patients receiving service | | |

<p>| Estimated Incentive Payment: $15,719.30 | Estimated Incentive Payment: $36,481.00 | Estimated Incentive Payment: $36,481.00 | Estimated Incentive Payment: $36,481.00 |</p>
<table>
<thead>
<tr>
<th>Related Category 1 or 2:</th>
<th>MHMRA of Harris County</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be collected in DY3 from the 250 patients expected to be served that DY</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 3: P-3:** Develop and test data systems  
**Metric 3:** Review satisfaction measures for use with the target population and their clinical teams  
**Data Source:** Project record—summary of reviews  
**Goal:** Identify/modify one instrument to test in Yr. 3

**Milestone 8: P-3:** Develop and test data systems  
**Metric 8:** Review satisfaction measures for use with the target population  
**Data Source:** Project record—summary of reviews, completed surveys  
**Goal:** Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3

**Estimated Incentive Payment:**  
**Year 2:** $15,719.30  
**Year 3:** $36,481.00
<table>
<thead>
<tr>
<th>Milestone 4: P-4:</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Study Act (PDSA) cycles to improve data collection and intervention activities</strong></td>
<td><strong>Metric 4: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</strong></td>
<td><strong>Metric 4: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</strong></td>
<td><strong>Metric 4: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</strong></td>
<td><strong>Metric 4: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</strong></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $15,719.30</td>
<td><strong>Estimated Incentive Payment:</strong> $15,719.30</td>
<td><strong>Estimated Incentive Payment:</strong> $36,481.00</td>
<td><strong>Estimated Incentive Payment:</strong> $36,481.00</td>
<td><strong>Estimated Incentive Payment:</strong> $36,481.00</td>
</tr>
</tbody>
</table>

**Milestone 5: P-5** Disseminate findings, including lessons learned and best practices, to stakeholders

**Metric 5: Report status, progress and lessons learned to stakeholders**

**Data Source:** management team minutes, RHP collaborations

**Goal:** To disseminate information about the project and solicit input from stakeholders

**Milestone 10: P-5:** Disseminate findings to stakeholders

**Metric 10:** Report status, progress and lessons learned to stakeholders

**Data Source:** management team minutes, RHP collaborations

**Goal:** To disseminate information about the project and solicit input from stakeholders
<table>
<thead>
<tr>
<th>Related Category 1 or 2:</th>
<th>MHMRA of Harris County</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
<th>113180703.6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be collected in DY3 from the 250 patients expected to be served that DY Year 2 (10/1/2012 – 9/30/2013)</td>
<td></td>
<td>113180703.1.6</td>
</tr>
<tr>
<td>Year 2 Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment: $15,719.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td>$78,596.48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Estimated Incentive Payment: $36,481.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount:</td>
<td>$182,405.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 4 Estimated Outcome Amount: $194,919.26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td>Year 5 Estimated Outcome Amount: $423,737.53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</td>
<td></td>
<td></td>
<td>$879,658.28</td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.7

Outcome Measure Description:
IT-6.1: Percent improvement over baseline of patient satisfaction scores
- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5% over baseline scores for the communication with provider domain as measured by the CAPHS survey
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10% over baseline scores for the communication with provider domain as measured by the CAPHS survey

Rationale:
The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. This initiative will permit MHMRA, the performing provider, to improve on previous efforts to
measure patient experience, through selection of reliable, valid measures with external benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain of “How Well their Doctors Communicate” by DY2.

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Both the Adult Visit Survey and the Adult Twelve Month Survey versions of the CAHPS questionnaire will be employed. Every new patient referred for outpatient services will receive the Adult Visit Survey after the completion of their first outpatient visit then the Adult Twelve Month Survey version will be used yearly for ongoing patients.

**Outcome Measure Valuation:**
Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1: P-1:** Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
**Metric 1:** Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information  
**Data Source:** Meetings minutes, project flow charts and timelines  
**Goal:** To integrate stakeholder input in development of program plan

**Milestone 6: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
**Metric 6:** Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information  
**Data Source:** Meetings minutes, project flow charts and timelines  
**Goal:** To complete project planning process and implement

**Milestone 11: OD-6:** Patient Satisfaction  
**Metric 11:** IT 6-1 Percent improvement over baseline of patient satisfaction scores  
a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain  
b. Denominator: Number of patients who were administered the survey  
**Data Source:** Patient survey  
**Goal:** 5% increase over baseline

**Milestone 12: OD-6:** Patient Satisfaction  
**Metric 12:** IT 6-1 Percent improvement over baseline of patient satisfaction scores  
a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain  
b. Denominator: Number of patients who were administered the survey  
**Data Source:** Patient survey  
**Goal:** 10% increase over baseline

**Estimated Incentive Payment:**  
$15,719.30  
$36,481.00  
$194,919.26  
$423,737.53

**Milestone 2: P-2:** Establish baseline  
**Metric 2:** Identify domains of patient satisfaction to be measured  
**Data Source:** literature review  
**Goal:** determine how baseline will be established for patient satisfaction domain

**Milestone 7: P-2:** Establish baseline  
**Metric 7:** Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction  
**Data Source:** Clinical records; monthly management reports  
**Goal:** obtain baseline of satisfaction survey from patients receiving service

**Estimated Incentive Payment:**  
$15,719.30  
$36,481.00
### Percent improvement over baseline of patient satisfaction scores

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 3: P-3:** Develop and test data systems
**Metric 3:** Review satisfaction measures for use with the target population and their clinical teams
**Data Source:** Project record—summary of reviews
**Goal:** Identify/modify one instrument to test in Yr. 3

**Milestone 8: P-3:** Develop and test data systems
**Metric 8:** Review satisfaction measures for use with the target population
**Data Source:** Project record—summary of reviews, completed surveys
**Goal:** Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3

**Estimated Incentive Payment:** $15,719.30

**Milestone 4: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 4:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
**Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement
**Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations

**Milestone 9: P-9:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 9:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
**Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement
**Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations

**Estimated Incentive Payment:** $36,481.00
<table>
<thead>
<tr>
<th>Related Category 1 or 2:</th>
<th>113180703.1.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be collected in DY3 from the 250 patients expected to be served that DY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
</tr>
<tr>
<td>$15,719.30</td>
<td>$36,481.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5:</strong> P-5: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Milestone 10:</strong> P-5: Disseminate findings to stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 5:</strong> Report status, progress and lessons learned to stakeholders</td>
<td><strong>Metric 10:</strong> Report status, progress and lessons learned to stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$15,719.30</td>
<td>$36,481.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong></td>
<td><strong>Year 3 Estimated Outcome Amount:</strong></td>
<td><strong>Year 4 Estimated Outcome Amount:</strong></td>
<td><strong>Year 5 Estimated Outcome Amount:</strong></td>
</tr>
<tr>
<td>$78,596.48</td>
<td>$182,405.01</td>
<td>$194,919.26</td>
<td>$423,737.53</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $879,658.28
Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.8

Outcome Measure Description:

IT-6.1: Percent improvement over baseline of patient satisfaction scores
- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5% over baseline scores for the communication with provider domain as measured by the CAPHS survey
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10% over baseline scores for the communication with provider domain as measured by the CAPHS survey

Rationale:
The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. This initiative will permit MHMRA, the performing provider, to improve on previous efforts to measure patient experience, through selection of reliable, valid measures with external...
benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain of “How Well their Doctors Communicate” by DY2.

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient experience is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Both the Adult Visit Survey and the Adult Twelve Month Survey versions of the CAHPS questionnaire will be employed. Every new patient referred for outpatient services will receive the Adult Visit Survey after the completion of their first outpatient visit then the Adult Twelve Month Survey version will be used yearly for ongoing patients.

**Outcome Measure Valuation:**
Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>Milestone 1: P-1: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Milestone 6: P-1: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Milestone 11: OD-6: Patient Satisfaction Metric 11: IT 6-1 Percent improvement over baseline of patient satisfaction scores a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain b. Denominator: Number of patients who were administered the survey Data Source: Patient survey Goal: 5% increase over baseline</th>
<th>Milestone 12: OD-6: Patient Satisfaction Metric 12: IT 6-1 Percent improvement over baseline of patient satisfaction scores a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain b. Denominator: Number of patients who were administered the survey Data Source: Patient survey Goal: 10% increase over baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 2: P-2: Establish baseline Metric 2: Identify domains of patient satisfaction to be measured Data Source: literature review Goal: determine how baseline will be established for patient satisfaction domain</td>
<td>Milestone 7: P-2: Establish baseline Metric 7: Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction (CAPHS) Data Source: Clinical records; monthly management reports Goal: obtain baseline of satisfaction survey from patients receiving service in DY3, estimated to be 400</td>
<td>Estimated Incentive Payment: $283,348.56</td>
<td>Estimated Incentive Payment: $615,975.14</td>
</tr>
<tr>
<td>Estimated Incentive Payment: $22,850.69</td>
<td>Estimated Incentive Payment: $53,031.39</td>
<td>Estimated Incentive Payment: $283,348.56</td>
<td>Estimated Incentive Payment: $615,975.14</td>
</tr>
<tr>
<td>Estimated Incentive Payment: $22,850.69</td>
<td>Estimated Incentive Payment: $53,031.39</td>
<td>Estimated Incentive Payment: $283,348.56</td>
<td>Estimated Incentive Payment: $615,975.14</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
</tbody>
</table>

**Milestone 3: P-3:** Develop and test data systems  
**Metric 3:** Review satisfaction measures for use with the target population and their clinical teams  
**Data Source:** Project record—summary of reviews  
**Goal:** Identify/modify one instrument to test in Yr. 3

**Milestone 8: P-3:** Develop and test data systems  
**Metric 8:** Review satisfaction measures for use with the target population  
**Data Source:** Project record—summary of reviews, completed surveys  
**Goal:** Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3

**Estimated Incentive Payment:** $22,850.69

**Milestone 4: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Metric 4:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles  
**Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement  
**Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations

**Milestone 9: P-9:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Metric 9:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles  
**Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement  
**Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations

**Estimated Incentive Payment:** $53,031.39
<table>
<thead>
<tr>
<th>Metric 5:</th>
<th>Year 2 Estimated Outcome Amount: $114,253.45</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Milestone 5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders</td>
</tr>
<tr>
<td></td>
<td>Metric 5: Report status, progress and lessons learned to stakeholders</td>
</tr>
<tr>
<td></td>
<td>Data Source: management team minutes, RHP collaborations</td>
</tr>
<tr>
<td></td>
<td>Goal: To disseminate information about the project and solicit input from stakeholders</td>
</tr>
<tr>
<td>Milestone 5: P-5</td>
<td>Estimated Incentive Payment: $22,850.69</td>
</tr>
<tr>
<td>Milestone 10: P-5</td>
<td>Estimated Incentive Payment: $53,031.39</td>
</tr>
<tr>
<td>Metric 10:</td>
<td>Report status, progress and lessons learned to stakeholders</td>
</tr>
<tr>
<td>Data Source:</td>
<td>management team minutes, RHP collaborations</td>
</tr>
<tr>
<td>Goal:</td>
<td>To disseminate information about the project and solicit input from stakeholders</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $114,253.45</td>
<td>Year 3 Estimated Outcome Amount: $265,156.95</td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount: $265,156.95</td>
<td>Year 4 Estimated Outcome Amount: $283,348.56</td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount: $283,348.56</td>
<td>Year 5 Estimated Outcome Amount: $615,975.14</td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount: $615,975.14</td>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,278,734.11</td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.9

Outcome Measure Description:
- IT-6.1: Percent improvement over baseline of patient satisfaction scores
  - Numerator: Percent improvement in targeted patient satisfaction domain
  - Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5% over baseline scores for the communication with provider domain as measured by the CAPHS survey
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10% over baseline scores for the communication with provider domain as measured by the CAPHS survey

Rationale:
The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. This initiative will permit MHMRA, the performing provider, to improve on previous efforts to measure patient experience, through selection of reliable, valid measures with external
benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain of “How Well their Doctors Communicate” by DY2.

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient experience is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Both the Adult Visit Survey and the Adult Twelve Month Survey versions of the CAHPS questionnaire will be employed. Every new patient referred for outpatient services will receive the Adult Visit Survey after the completion of their first outpatient visit then the Adult Twelve Month Survey version will be used yearly for ongoing patients.

**Outcome Measure Valuation:**
Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
### Percent improvement over baseline of patient satisfaction scores

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
<th>Data Source</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IT-6.1</strong></td>
<td>IT-6.1</td>
<td>IT-6.1</td>
<td>IT-6.1</td>
</tr>
<tr>
<td><strong>Percent improvement over baseline</strong></td>
<td><strong>Percent improvement over baseline</strong></td>
<td><strong>Percent improvement over baseline</strong></td>
<td><strong>Percent improvement over baseline</strong></td>
</tr>
<tr>
<td><strong>Numerator</strong>: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain</td>
<td><strong>Numerator</strong>: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain</td>
<td><strong>Numerator</strong>: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain</td>
<td><strong>Numerator</strong>: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain</td>
</tr>
<tr>
<td><strong>Denominator</strong>: Number of patients who were administered the survey</td>
<td><strong>Denominator</strong>: Number of patients who were administered the survey</td>
<td><strong>Denominator</strong>: Number of patients who were administered the survey</td>
<td><strong>Denominator</strong>: Number of patients who were administered the survey</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Patient survey</td>
<td><strong>Data Source</strong>: Patient survey</td>
<td><strong>Data Source</strong>: Patient survey</td>
<td><strong>Data Source</strong>: Patient survey</td>
</tr>
<tr>
<td><strong>Goal</strong>: 5% increase over baseline</td>
<td><strong>Goal</strong>: 10% increase over baseline</td>
<td><strong>Goal</strong>: 15% increase over baseline</td>
<td><strong>Goal</strong>: 20% increase over baseline</td>
</tr>
</tbody>
</table>

### Starting Point/Baseline:
Baseline will be taken from the 300 patients expected in DY3.

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1: P-1</strong>: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 6: P-1</strong>: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 11: OD-6</strong>: Patient Satisfaction</td>
<td><strong>Milestone 12: OD-6</strong>: Patient Satisfaction</td>
</tr>
<tr>
<td><strong>Metric 1</strong>: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td><strong>Metric 6</strong>: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td><strong>Metric 11: IT 6-1 Percent improvement over baseline of patient satisfaction scores</strong></td>
<td><strong>Metric 12: IT 6-1 Percent improvement over baseline of patient satisfaction scores</strong></td>
</tr>
<tr>
<td><strong>Data Source</strong>: Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source</strong>: Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source</strong>: Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source</strong>: Meetings minutes, project flow charts and timelines</td>
</tr>
<tr>
<td><strong>Goal</strong>: To integrate stakeholder input in development of program plan</td>
<td><strong>Goal</strong>: To complete project planning process and implement</td>
<td><strong>Goal</strong>: Complete project planning process</td>
<td><strong>Goal</strong>: Complete project planning process</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment</strong>: $21,987.21</td>
<td><strong>Estimated Incentive Payment</strong>: $51,027.44</td>
<td><strong>Estimated Incentive Payment</strong>: $272,641.38</td>
<td><strong>Estimated Incentive Payment</strong>: $592,698.66</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 2: P-2</strong>: Establish baseline</td>
<td><strong>Milestone 7: P-2</strong>: Establish baseline</td>
<td><strong>Milestone 11: OD-6</strong>: Patient Satisfaction</td>
<td><strong>Milestone 12: OD-6</strong>: Patient Satisfaction</td>
</tr>
<tr>
<td><strong>Metric 2</strong>: Identify domains of patient satisfaction to be measured</td>
<td><strong>Metric 7</strong>: Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction</td>
<td><strong>Metric 11: IT 6-1 Percent improvement over baseline of patient satisfaction scores</strong></td>
<td><strong>Metric 12: IT 6-1 Percent improvement over baseline of patient satisfaction scores</strong></td>
</tr>
<tr>
<td><strong>Data Source</strong>: literature review</td>
<td><strong>Data Source</strong>: Clinical records; monthly management reports</td>
<td><strong>Data Source</strong>: Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source</strong>: Meetings minutes, project flow charts and timelines</td>
</tr>
<tr>
<td><strong>Goal</strong>: determine how baseline will be established for patient satisfaction domain</td>
<td><strong>Goal</strong>: obtain baseline of satisfaction survey from patients receiving service</td>
<td><strong>Goal</strong>: Establish baseline</td>
<td><strong>Goal</strong>: Establish baseline</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment</strong>: $21,987.21</td>
<td><strong>Estimated Incentive Payment</strong>: $51,027.44</td>
<td><strong>Estimated Incentive Payment</strong>: $272,641.38</td>
<td><strong>Estimated Incentive Payment</strong>: $592,698.66</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
</tbody>
</table>
| **Milestone 3: P-3:** Develop and test data systems  
**Metric 3:** Review satisfaction measures for use with the target population and their clinical teams  
**Data Source:** Project record—summary of reviews  
**Goal:** Identify/modify one instrument to test in Yr. 3 | **Milestone 8: P-3:** Develop and test data systems  
**Metric 8:** Review satisfaction measures for use with the target population  
**Data Source:** Project record—summary of reviews, completed surveys  
**Goal:** Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3 | | |
<p>| <strong>Estimated Incentive Payment:</strong> $21,987.21 | <strong>Estimated Incentive Payment:</strong> $51,027.44 | | |</p>
<table>
<thead>
<tr>
<th>Related Category 1 or 2: MHMRA of Harris County</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2: 113180703.2.2</td>
<td>113180703</td>
</tr>
<tr>
<td>Starting Point/Baseline: Baseline will be taken from the 300 patients expected in DY3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 4: P-4:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td><strong>Milestone 9: P-9:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td><strong>Milestone 5: P-5</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Milestone 10:</strong> Disseminate findings to stakeholders</td>
</tr>
<tr>
<td>Metric 4: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td>Metric 9: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td>Metric 5: Report status, progress and lessons learned to stakeholders</td>
<td>Metric 10: Report status, progress and lessons learned to stakeholders</td>
</tr>
<tr>
<td>Data Source: Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td>Data Source: Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td>Data Source: management team minutes, RHP collaborations</td>
<td>Data Source: management team minutes, RHP collaborations</td>
</tr>
<tr>
<td>Goal: To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td>Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations</td>
<td>Goal: To disseminate information about the project and solicit input from stakeholders</td>
<td>Goal: To disseminate information about the project and solicit input from stakeholders</td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment:**
- **Year 2:** $21,987.21
- **Year 5:** $51,027.44
<table>
<thead>
<tr>
<th>MHMRA of Harris County</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2:</td>
<td>113180703.2.2</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be taken from the 300 patients expected in DY3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Incentive Payment: $21,987.21</td>
<td>Estimated Incentive Payment: $51,027.44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $109,936.04</td>
<td>Year 3 Estimated Outcome Amount: $255,137.20</td>
<td>Year 4 Estimated Outcome Amount: $272,641.38</td>
<td>Year 5 Estimated Outcome Amount: $592,698.66</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,230,413.28
**Title of Outcome** Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

**Unique RHP outcome identification numbers:** 113180703.3.10

**Outcome Measure Description:**

IT-6.1: Percent improvement over baseline of patient satisfaction scores
- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

**Process Milestones:**

- **DY 2:**
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

- **DY 3:**
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

**Outcome Improvement Targets for each year:**

- **DY 4:**
  - IT 6.1: Rate 1: Improve patient satisfaction by 5% over baseline scores for the communication with provider domain as measured by the CAPHs survey

- **DY 5:**
  - IT 6.1: Rate 1: Improve patient satisfaction by 10% over baseline scores for the communication with provider domain as measured by the CAPHs survey

**Rationale:**

The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department, and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. This initiative will permit MHMRA, the performing provider, to improve on previous efforts to
measure patient experience, through selection of reliable, valid measures with external benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain of “How Well their Doctors Communicate” by DY2.

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient experience is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Both the Adult Visit Survey and the Adult Twelve Month Survey versions of the CAHPS questionnaire will be employed. Every new patient referred for outpatient services will receive the Adult Visit Survey after the completion of their first outpatient visit then the Adult Twelve Month Survey version will be used yearly for ongoing patients.

**Outcome Measure Valuation:**
Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>Milestone 1: P-1:</th>
<th>Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1:</td>
<td>Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information.</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Meetings minutes, project flow charts and timelines.</td>
</tr>
<tr>
<td>Goal:</td>
<td>To integrate stakeholder input in development of program plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 6: P-1:</th>
<th>Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 6:</td>
<td>Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information.</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Meetings minutes, project flow charts and timelines.</td>
</tr>
<tr>
<td>Goal:</td>
<td>To complete project planning process and implement.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 11: IT 6-1</td>
<td>Percent improvement over baseline of patient satisfaction scores.</td>
</tr>
<tr>
<td>a. Numerator:</td>
<td>Percent improvement in targeted patient satisfaction as measured by the CAPHS domain.</td>
</tr>
<tr>
<td>b. Denominator:</td>
<td>Number of patients who were administered the survey.</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Patient survey.</td>
</tr>
<tr>
<td>Goal:</td>
<td>5% increase over baseline.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 12: IT 6-1</td>
<td>Percent improvement over baseline of patient satisfaction scores.</td>
</tr>
<tr>
<td>a. Numerator:</td>
<td>Percent improvement in targeted patient satisfaction as measured by the CAPHS domain.</td>
</tr>
<tr>
<td>b. Denominator:</td>
<td>Number of patients who were administered the survey.</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Patient survey.</td>
</tr>
<tr>
<td>Goal:</td>
<td>10% increase over baseline.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Incentive Payment:</td>
<td>$2,640.99</td>
<td>Estimated Incentive Payment:</td>
<td>$6,129.16</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 2: P-2:</th>
<th>Establish baseline.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 2:</td>
<td>Identify domains of patient satisfaction to be measured.</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Literature review.</td>
</tr>
<tr>
<td>Goal:</td>
<td>Determine how baseline will be established for patient satisfaction domain.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 7: P-2:</th>
<th>Establish baseline.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 7:</td>
<td>Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction.</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Clinical records, monthly management reports.</td>
</tr>
<tr>
<td>Goal:</td>
<td>Obtain baseline of satisfaction survey from patients receiving service.</td>
</tr>
</tbody>
</table>

<p>| Estimated Incentive Payment: | $2,640.99 | Estimated Incentive Payment: | $6,129.16 |</p>
<table>
<thead>
<tr>
<th>Milestone 3: P-3:</th>
<th>Milestone 8: P-3:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop and test data systems</td>
<td>Develop and test data systems</td>
</tr>
<tr>
<td>Metric 3: Review satisfaction measures for use with the target population and their clinical teams</td>
<td>Metric 8: Review satisfaction measures for use with the target population</td>
</tr>
<tr>
<td>Data Source: Project record—summary of reviews</td>
<td>Data Source: Project record—summary of reviews, completed surveys</td>
</tr>
<tr>
<td>Goal: Identify/modify one instrument to test in Yr. 3</td>
<td>Goal: Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3</td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment:**

- **Year 2:** $2,640.99
- **Year 3:** $6,129.16

---

<table>
<thead>
<tr>
<th>Milestone 4: P-4:</th>
<th>Milestone 9: P-9:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
</tr>
<tr>
<td>Metric 4: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td>Metric 9: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
</tr>
<tr>
<td>Data Source: Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td>Data Source: Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
</tr>
<tr>
<td>Goal: To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td>Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations</td>
</tr>
</tbody>
</table>

---

**Starting Point/Baseline:**
Baseline to be measured with about 1500 patients served in DY3

**Percent improvement over baseline of patient satisfaction scores**

<table>
<thead>
<tr>
<th>Related Category 1 or 2:</th>
<th>Starting Point/Baseline:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHMRA of Harris County</td>
<td>Baseline to be measured with about 1500 patients served in DY3</td>
</tr>
</tbody>
</table>

**Regional Healthcare Partnership Plan**

Region 3
<table>
<thead>
<tr>
<th>113180703.3.10</th>
<th>IT-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHMRA of Harris County</td>
<td>113180703</td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 1 or 2:</strong></td>
<td>113180703.2.3</td>
<td></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>Baseline to be measured with about 1500 patients served in DY3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Estimated Incentive Payment:</strong></td>
<td>$2,640.99</td>
<td>$6,129.16</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5:</strong></td>
<td>P-5 Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 5:</strong></td>
<td>Report status, progress and lessons learned to stakeholders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td>management team minutes, RHP collaborations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong></td>
<td>To disseminate information about the project and solicit input from stakeholders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong></td>
<td>$2,640.99</td>
<td>$6,129.16</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong></td>
<td>$13,204.96</td>
<td></td>
<td></td>
<td>$71,191.97</td>
</tr>
<tr>
<td><strong>Year 3 Estimated Outcome Amount:</strong></td>
<td>$30,645.79</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4 Estimated Outcome Amount:</strong></td>
<td>$32,748.30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5 Estimated Outcome Amount:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong></td>
<td>$147,791.02</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.11

Outcome Measure Description:
IT-6.1: Percent improvement over baseline of patient satisfaction scores
- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5% over baseline scores for the communication with provider domain as measured by the CAPHS survey
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10% over baseline scores for the communication with provider domain as measured by the CAPHS survey

Rationale:
The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. This initiative will permit MHMRA, the performing provider, to improve on previous efforts to
measure patient experience, through selection of reliable, valid measures with external benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain of “How Well their Doctors Communicate” by DY2.

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient experience is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Both the Adult Visit Survey and the Adult Twelve Month Survey versions of the CAHPS questionnaire will be employed. Every new patient referred for outpatient services will receive the Adult Visit Survey after the completion of their first outpatient visit then the Adult Twelve Month Survey version will be used yearly for ongoing patients.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>Milestone 1: P-1: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Metric 1: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</th>
<th>Goal: To integrate stakeholder input in development of program plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 6: P-1: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Metric 6: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td>Goal: To complete project planning process and implement</td>
</tr>
<tr>
<td>Milestone 11: OD-6: Patient Satisfaction</td>
<td>Metric 11: IT 6-1 Percent improvement over baseline of patient satisfaction scores</td>
<td></td>
</tr>
<tr>
<td>a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Denominator: Number of patients who were administered the survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Patient survey</td>
<td>Data Source: Clinical records; monthly management reports</td>
<td></td>
</tr>
<tr>
<td>Goal: 5% increase over baseline</td>
<td>Goal: obtain baseline of satisfaction survey from patients receiving service</td>
<td></td>
</tr>
<tr>
<td>Milestone 12: OD-6: Patient Satisfaction</td>
<td>Metric 12: IT 6-1 Percent improvement over baseline of patient satisfaction scores</td>
<td></td>
</tr>
<tr>
<td>a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Denominator: Number of patients who were administered the survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Patient survey</td>
<td>Data Source: Meetings minutes, project flow charts and timelines</td>
<td></td>
</tr>
<tr>
<td>Goal: 10% increase over baseline</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Estimated Incentive Payment

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,408.52</td>
<td>$3,268.86</td>
<td>$17,465.66</td>
<td>$37,968.82</td>
</tr>
</tbody>
</table>

**Regional Healthcare Partnership Plan**

**Region 3**
<table>
<thead>
<tr>
<th></th>
<th>IT-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHMRA of Harris County</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2:</td>
<td></td>
<td>113180703</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
<td>Baseline to be collected in DY 3 from the 40 anticipated patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 3: P-3:** Develop and test data systems  
**Metric 3:** Review satisfaction measures for use with the target population and their clinical teams  
**Data Source:** Project record—summary of reviews  
**Goal:** Identify/modify one instrument to test in Yr. 3

**Milestone 8: P-3:** Develop and test data systems  
**Metric 8:** Review satisfaction measures for use with the target population  
**Data Source:** Project record—summary of reviews, completed surveys  
**Goal:** Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3

**Estimated Incentive Payment:**  
Year 2: $1,408.52  
Year 4: $3,268.86
<table>
<thead>
<tr>
<th>Related Category 1 or 2: MHMRA of Harris County</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline: Baseline to be collected in DY 3 from the 40 anticipated patients</td>
<td>113180703.2.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 4: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Metric 4:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles  
**Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement  
**Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations

**Estimated Incentive Payment:** $1,408.52

**Milestone 5: P-5** Disseminate findings, including lessons learned and best practices, to stakeholders  
**Metric 5:** Report status, progress and lessons learned to stakeholders  
**Data Source:** management team minutes, RHP collaborations  
**Goal:** To disseminate information about the project and solicit input from stakeholders

**Estimated Incentive Payment:** $3,268.86

**Milestone 6:** P-6  
**Metric 6:**  
**Data Source:**  
**Goal:**

**Milestone 7:** P-7  
**Metric 7:**  
**Data Source:**  
**Goal:**

**Milestone 8:** P-8  
**Metric 8:**  
**Data Source:**  
**Goal:**

<table>
<thead>
<tr>
<th>Milestone 9: P-9</th>
<th>Milestone 10: P-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>Disseminate findings to stakeholders</td>
</tr>
<tr>
<td>Metric 9: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td>Metric 10: Report status, progress and lessons learned to stakeholders</td>
</tr>
<tr>
<td>Data Source: Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td>Data Source: management team minutes, RHP collaborations</td>
</tr>
<tr>
<td>Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations</td>
<td>Goal: To disseminate information about the project and solicit input from stakeholders</td>
</tr>
</tbody>
</table>
Percent improvement over baseline of patient satisfaction scores

<table>
<thead>
<tr>
<th>MHMRA of Harris County</th>
<th>113180703.3.11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2:</td>
<td>113180703.2.4</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline to be collected in DY 3 from the 40 anticipated patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
</tr>
<tr>
<td>$1,408.52</td>
<td>$3,268.86</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome</td>
<td>Year 3 Estimated Outcome</td>
<td>Year 4 Estimated Outcome</td>
<td>Year 5 Estimated Outcome</td>
</tr>
<tr>
<td>Amount: $7,042.60</td>
<td>Amount: $16,344.32</td>
<td>Amount: $17,465.66</td>
<td>Amount: $37,968.82</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $78,821.41
Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.12

Outcome Measure Description:
IT-6.1: Percent improvement over baseline of patient satisfaction scores

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5% over baseline scores for the communication with provider domain as measured by the CAPHS survey
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10% over baseline scores for the communication with provider domain as measured by the CAPHS survey

Rationale:
The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. This initiative will permit MHMRA, the performing provider, to improve on previous efforts to
measure patient experience, through selection of reliable, valid measures with external benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain of “How Well their Doctors Communicate” by DY2.

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient experience is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Both the Adult Visit Survey and the Adult Twelve Month Survey versions of the CAHPS questionnaire will be employed. Every new patient referred for outpatient services will receive the Adult Visit Survey after the completion of their first outpatient visit then the Adult Twelve Month Survey version will be used yearly for ongoing patients.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>Milestone 1: P-1:</th>
<th>Milestone 6: P-1:</th>
<th>Milestone 11: OD-6:</th>
<th>Milestone 12: OD-6:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Patient Satisfaction</td>
<td>Patient Satisfaction</td>
</tr>
<tr>
<td>Metric 1: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td>Metric 6: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td>Metric 11: IT 6-1 Percent improvement over baseline of patient satisfaction scores</td>
<td>Metric 12: IT 6-1 Percent improvement over baseline of patient satisfaction scores</td>
</tr>
<tr>
<td>Data Source: Meetings minutes, project flow charts and timelines</td>
<td>Data Source: Meetings minutes, project flow charts and timelines</td>
<td>a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain</td>
<td>a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain</td>
</tr>
<tr>
<td>Goal: To integrate stakeholder input in development of program plan</td>
<td>Goal: To complete project planning process and implement</td>
<td>b. Denominator: Number of patients who were administered the survey</td>
<td>b. Denominator: Number of patients who were administered the survey</td>
</tr>
<tr>
<td>Estimated Incentive Payment: $14,252.23</td>
<td>Estimated Incentive Payment: $33,076.27</td>
<td>Estimated Incentive Payment: $176,727.65</td>
<td>Estimated Incentive Payment: $384,190.54</td>
</tr>
</tbody>
</table>

**Starting Point/Baseline:** Baseline will be collected from new patients in DY3, anticipated to be about 200
<table>
<thead>
<tr>
<th>Milestone 3: P-3: Develop and test data systems</th>
<th>Milestone 8: P-3: Develop and test data systems</th>
<th>Milestone 9: P-9: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 3: Review satisfaction measures for use with the target population and their clinical teams</td>
<td>Metric 8: Review satisfaction measures for use with the target population</td>
<td>Metric 9: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
</tr>
<tr>
<td>Data Source: Project record—summary of reviews</td>
<td>Data Source: Project record—summary of reviews, completed surveys</td>
<td>Data Source: Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
</tr>
<tr>
<td>Goal: Identify/modify one instrument to test in Yr. 3</td>
<td>Goal: Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3</td>
<td>Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations</td>
</tr>
<tr>
<td>Estimated Incentive Payment: $14,252.23</td>
<td>Estimated Incentive Payment: $33,076.27</td>
<td></td>
</tr>
</tbody>
</table>

**Starting Point/Baseline:** Baseline will be collected from new patients in DY3, anticipated to be about 200
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $14,252.23</td>
<td><strong>Estimated Incentive Payment:</strong> $33,076.27</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Milestone 5: P-5** Disseminate findings, including lessons learned and best practices, to stakeholders  
**Metric 5:** Report status, progress and lessons learned to stakeholders  
**Data Source:** management team minutes, RHP collaborations  
**Goal:** To disseminate information about the project and solicit input from stakeholders

**Milestone 10: P-5:** Disseminate findings to stakeholders  
**Metric 10:** Report status, progress and lessons learned to stakeholders  
**Data Source:** management team minutes, RHP collaborations  
**Goal:** To disseminate information about the project and solicit input from stakeholders

**Year 2 Estimated Outcome Amount:** $71,261.15  
**Year 3 Estimated Outcome Amount:** $165,381.34  
**Year 4 Estimated Outcome Amount:** $176,727.65  
**Year 5 Estimated Outcome Amount:** $384,190.54

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $797,560.68
**Title of Outcome Measure (Improvement Target):** IT-6.1: Percent improvement over baseline of patient satisfaction scores

**Unique RHP outcome identification numbers:** 113180703.3.13

**Outcome Measure Description:**
IT-6.1: Percent improvement over baseline of patient satisfaction scores
- Numerator: Percent improvement in CSQ8 scores
- Denominator: Number of patients who were administered the survey

**Process Milestones:**
- **DY 2:**
  - P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders
- **DY 3:**
  - P-2: Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders

**Outcome Improvement Targets for each year:**
- **DY 4:**
  - IT 6.1: Obtain a total average score for patients served of 2.5 or higher on the CSQ8 measure of patient satisfaction
- **DY 5:**
  - IT 6.1: Increase total average score for patients served on the CSQ8 measure of patient satisfaction by 25% over DY4

**Rationale:**
The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. This initiative will permit MHMRA, the performing provider, to improve on previous efforts to measure patient experience, through selection of reliable, valid measures with external...
benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain as measured by the CSQ-8.

The goals for improvement have been set at an average score of 2.5 in DY 4 and a 25% increase in scores over DY4 in DY5. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient experience is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Patients entering services will be given the CSQ-8 upon completion.

**Outcome Measure Valuation:**
Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe that if patients are satisfied with services received and communication with providers, they would be more willing to continue in ongoing services, thereby reducing preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>Milestone 1: P-1:</th>
<th>Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1:</td>
<td>Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Meetings minutes, project flow charts and timelines</td>
</tr>
<tr>
<td>Goal:</td>
<td>To integrate stakeholder input in development of program plan</td>
</tr>
<tr>
<td>Milestone 6: P-2:</td>
<td>Establish baseline</td>
</tr>
<tr>
<td>Metric 1:</td>
<td>Identify domains of patient satisfaction to be measured</td>
</tr>
<tr>
<td>Data Source:</td>
<td>CSQ8</td>
</tr>
<tr>
<td>Goal:</td>
<td>Establish baseline of patient satisfaction measures with the patients served throughout DY3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 2: P-2:</td>
<td>Establish baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1:</td>
<td>Identify domains of patient satisfaction to be measured</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source:</td>
<td>Literature review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal:</td>
<td>Determine how baseline will be established for patient satisfaction domain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 7: P-3:</td>
<td>Develop and test data systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1:</td>
<td>Review satisfaction measures for use with the target population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source:</td>
<td>Project record—summary of reviews, completed surveys</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal:</td>
<td>Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3, using the patients served in DY3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 11: OD-6:</td>
<td>Patient Satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1:</td>
<td>IT 6-1 Percent improvement over baseline of patient satisfaction scores</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Numerator:</td>
<td>Total average score of the CSQ8 measure of patient satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Denominator:</td>
<td>Number of patients who were administered the survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source:</td>
<td>CSQ8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal:</td>
<td>Obtain an average score of 2.5 or higher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 12: OD-6:</td>
<td>Patient Satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric 1: IT 6-1 Percent improvement over baseline of patient satisfaction scores</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Numerator:</td>
<td>Total average score of the CSQ8 measure of patient satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Denominator:</td>
<td>Number of patients who were administered the survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source:</td>
<td>CSQ8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal:</td>
<td>Increase 25% over average DY4 score</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Estimated Incentive Payment: | $16,978.17 | $49,253.21 | $210,529.29 | $457,105.33 |

Regional Healthcare Partnership Plan
Region 3

2124
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Incentive Payment: $16,978.17</td>
<td>Estimated Incentive Payment: $49,253.21</td>
<td>Milestone 8: P-9: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td></td>
</tr>
<tr>
<td>Milestone 3: P-3: Develop and test data systems</td>
<td>Metric 1: Review satisfaction measures for use with the target population and their clinical teams</td>
<td>Metric 1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td></td>
</tr>
<tr>
<td>Data Source: Project record—summary of reviews</td>
<td>Goal: Identify/modify one instrument to test in Yr. 3</td>
<td>Data Source: Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td></td>
</tr>
<tr>
<td>Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations</td>
<td>Estimated Incentive Payment: $16,978.17</td>
<td>Estimated Incentive Payment: $49,253.21</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Milestone 4: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>Milestone 5: P-5: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>Milestone 9: P-5: Disseminate findings to stakeholders</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td><strong>Metric 1:</strong> Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td><strong>Metric 5:</strong> Report status, progress and lessons learned to stakeholders</td>
<td><strong>Metric 1:</strong> Report status, progress and lessons learned to stakeholders</td>
</tr>
<tr>
<td></td>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
</tr>
<tr>
<td></td>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders</td>
</tr>
<tr>
<td></td>
<td>Estimated Incentive Payment: $16,978.17</td>
<td>Estimated Incentive Payment: $16,978.17</td>
<td>Estimated Incentive Payment: $49,253.21</td>
</tr>
</tbody>
</table>

**Starting Point/Baseline:** Baseline to be established in DY 3 with the estimated 100 patients

**MHMRA of Harris County**

**Related Category 1 or 2:**

**Baseline to be established in DY 3 with the estimated 100 patients**

**Estimated Incentive Payment:**

**Estimated Incentive Payment:**

**Estimated Incentive Payment:**
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: $84,890.84</td>
<td>Year 3 Estimated Outcome Amount: $197,012.84</td>
<td>Year 4 Estimated Outcome Amount: $210,529.29</td>
<td>Year 5 Estimated Outcome Amount: $457,105.33</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $950,105.33**
Title of Outcome Measure (Improvement Target): IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Unique RHP outcome identification numbers: 113180703.3.14

Outcome Measure Description:
IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings
- The number of permanent members who had a potentially preventable admission/readmission to a criminal justice setting during the demonstration years

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baselines for patients served
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT-9.1: Decrease in the number of permanent members who had a potentially preventable admission/readmission to a criminal justice setting during the demonstration year by 5% from baseline
- DY 5:
  - IT-9.1: Decrease in the number permanent members who had a potentially preventable admission/readmission to a criminal justice setting during the demonstration years by 10% from baseline

Rationale:
The Process milestones were chosen as stated above in order to develop a strong collaborative team approach between the clinical staff, administrators, stake-holders, law-enforcement officers, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. The first steps in DY 2 will be project planning (P-1) then establishment of baselines (P-2) for the number of permanent members and the number of arrests. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). In DY 3 a similar process will provide for accurate measurement of baselines from which to measure the success of the psychosocial rehab intervention. In
particular, we chose to add Process milestone P-3 Develop and test data systems in order to determine any new systemic changes in data collection that the collaborations may have allowed for that may not have been available in DY2.

We hope that the ratio of arrests to intervention will decrease as the enhancement and development of the St. Joseph House take place. At this time, we are not selecting a specific metric or percent of expected change. The rationale for determining this rate at a later time is that the base rate of arrests is expected to be low and the percent of change will need to appropriately reflect meaningful changes in arrests. St. Joseph House administrators and stakeholders will work in conjunction with the MHMRA Outcomes Department and the MHMRA Quality Improvement Department to determine an appropriate rate of change.

Once initial rates of change in DY 4 have been determined another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in reducing preventable mental health admissions and readmissions to criminal justice settings. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:**

We have selected preventable mental health admissions/readmissions to criminal justice setting as a measure because many of the individuals in the CIRT program have a history of arrests. In recent surveys it has been noted that 25% of the inmates in Harris County Jail are receiving psychotropic medications. Further, more than 16% have histories of treatment within the public mental health system. In many instances, it appear likely that individuals with mental disorders are arrested and jailed at significant public expense when appropriate mental health care could potentially avert criminalization of episodes of untreated mental disorder. It is also important to note that all patients have a right to be treated in the least-restrictive environment possible; therefore, the CIRT is an intervention that would ensure patients’ rights are respected and community treatment is more likely.
<table>
<thead>
<tr>
<th>Milestone</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1: P-1:</strong> Project planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>(10/1/2012 – 9/30/2013)</td>
<td>(10/1/2013 – 9/30/2014)</td>
<td>(10/1/2014 – 9/30/2015)</td>
<td>(10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Metric 1: P-1:</strong> Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td><strong>Data Source:</strong> Meetings minutes and timelines</td>
<td><strong>Goal:</strong> To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way</td>
<td><strong>Data Source:</strong> MHMRA and police records</td>
<td><strong>Goal:</strong> Establish baseline</td>
</tr>
<tr>
<td><strong>Milestone 2: P-3:</strong> Develop and test data systems</td>
<td><strong>Metric 2: P-3:</strong> Develop and test systems to track baseline data for PSYCHOSOCIAL</td>
<td><strong>Data Source:</strong> Meeting minutes</td>
<td><strong>Goal:</strong> Establish method to track CIRT data across multiple organizations (e.g., MHMRA and police departments)</td>
<td><strong>Data Source:</strong> MHMRA and police records</td>
</tr>
<tr>
<td><strong>Milestone 3: P-2:</strong> Establish Baselines</td>
<td><strong>Metric 5: P-2:</strong> Percent of arrests per consumer pre/post psychosocial rehab intervention</td>
<td><strong>Goal:</strong> Test and revise data collection system in order to measure of baseline by end of Yr. 3</td>
<td><strong>Data Sources:</strong> MHMRA, Police records</td>
<td><strong>Goal:</strong> 10% reduction in arrests from baseline</td>
</tr>
<tr>
<td><strong>Metric 6:</strong> P-3 Develop and test data systems</td>
<td><strong>Metric 6:</strong> Establish and test data collection protocol incorporating available law enforcement data</td>
<td><strong>Data Source:</strong> Law enforcement partners, project records</td>
<td><strong>Goal:</strong> Establish baseline</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 4:</strong> OD-9: Right Care, Right Setting</td>
<td><strong>Metric 9:</strong> IT-9.1: Decrease in criminal justice arrests</td>
<td><strong>a. Numerator:</strong> The number of arrests per year per consumer after receiving intervention.</td>
<td><strong>Data Sources:</strong> MHMRA and police records</td>
<td></td>
</tr>
<tr>
<td><strong>Metric 10:</strong> IT-9.1: Decrease in criminal justice arrests</td>
<td><strong>b. Denominator:</strong> The number of arrests per year per consumer before receiving intervention.</td>
<td><strong>Goal:</strong> 5% reduction in arrests from baseline</td>
<td><strong>Goal:</strong> 10% reduction in arrests from baseline</td>
<td></td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment:**
- Year 2: $10,766.52
- Year 3: $24,986.71
- Year 4: $106,803.87
- Year 5: $232,182.32
<table>
<thead>
<tr>
<th>Milestone 3: P-4:</th>
<th>Milestone 7: P-4:</th>
<th>Milestone 4: P-5:</th>
<th>Milestone 8: P-5:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct Plan Do</td>
<td>Conduct Plan Do</td>
<td>Disseminate</td>
<td>Disseminate</td>
</tr>
<tr>
<td>Study Act (PDSA)</td>
<td>Study Act (PDSA)</td>
<td>findings,</td>
<td>findings,</td>
</tr>
<tr>
<td>cycles to</td>
<td>cycles to</td>
<td>lessons learned</td>
<td>lessons learned</td>
</tr>
<tr>
<td>improve data</td>
<td>improve data</td>
<td>and best</td>
<td>and best</td>
</tr>
<tr>
<td>collection and</td>
<td>collection and</td>
<td>practices, to</td>
<td>practices, to</td>
</tr>
<tr>
<td>intervention</td>
<td>intervention</td>
<td>stakeholders</td>
<td>stakeholders</td>
</tr>
<tr>
<td>activities</td>
<td>activities</td>
<td>Metric 3: P-4:</td>
<td>Metric 4: P-5:</td>
</tr>
<tr>
<td>Metric 7: P-4:</td>
<td>Metric 7: P-4:</td>
<td>Report status,</td>
<td>Report status,</td>
</tr>
<tr>
<td>Project planning</td>
<td>Project planning</td>
<td>progress and</td>
<td>progress and</td>
</tr>
<tr>
<td>and</td>
<td>and</td>
<td>lessons learned</td>
<td>lessons learned</td>
</tr>
<tr>
<td>implementation</td>
<td>implementation</td>
<td>to stakeholders</td>
<td>to stakeholders</td>
</tr>
<tr>
<td>documentation</td>
<td>documentation</td>
<td>Metric 3: P-4:</td>
<td>Metric 4: P-5:</td>
</tr>
<tr>
<td>demonstrates</td>
<td>demonstrates</td>
<td>Project status,</td>
<td>Project status,</td>
</tr>
<tr>
<td>plan, do, study</td>
<td>plan, do, study</td>
<td>progress and</td>
<td>progress and</td>
</tr>
<tr>
<td>act</td>
<td>act</td>
<td>lessons learned</td>
<td>lessons learned</td>
</tr>
<tr>
<td>quality</td>
<td>quality</td>
<td>to stakeholders</td>
<td>to stakeholders</td>
</tr>
<tr>
<td>improvement</td>
<td>improvement</td>
<td>Metric 3: P-4:</td>
<td>Metric 4: P-5:</td>
</tr>
<tr>
<td>cycles</td>
<td>cycles</td>
<td>Data Source:</td>
<td>Data Source:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Meeting minutes</td>
<td>Meeting minutes</td>
</tr>
<tr>
<td>Goal: To improve</td>
<td>Goal: To improve</td>
<td>Goal: To</td>
<td>Goal: To</td>
</tr>
<tr>
<td>processes and</td>
<td>processes and</td>
<td>disseminate</td>
<td>disseminate</td>
</tr>
<tr>
<td>outcomes by</td>
<td>outcomes by</td>
<td>information</td>
<td>information</td>
</tr>
<tr>
<td>implementing</td>
<td>implementing</td>
<td>about the</td>
<td>about the</td>
</tr>
<tr>
<td>data-driven</td>
<td>data-driven</td>
<td>project and</td>
<td>project and</td>
</tr>
<tr>
<td>course</td>
<td>course</td>
<td>solicit input</td>
<td>solicit input</td>
</tr>
<tr>
<td>corrections</td>
<td>corrections</td>
<td>from stakeholders</td>
<td>from stakeholders</td>
</tr>
<tr>
<td>and innovations</td>
<td>and innovations</td>
<td>representing</td>
<td>representing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>consumers,</td>
<td>consumers,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>families,</td>
<td>families,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>public agencies</td>
<td>public agencies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and private</td>
<td>and private</td>
</tr>
<tr>
<td></td>
<td></td>
<td>providers</td>
<td>providers</td>
</tr>
<tr>
<td>Estimated</td>
<td>Estimated</td>
<td>Estimated</td>
<td>Estimated</td>
</tr>
<tr>
<td>Incentive</td>
<td>Incentive</td>
<td>Incentive</td>
<td>Incentive</td>
</tr>
<tr>
<td>Payment:</td>
<td>Payment:</td>
<td>Payment:</td>
<td>Payment:</td>
</tr>
<tr>
<td>$10,766.52</td>
<td>$10,766.52</td>
<td>$24,986.71</td>
<td>$24,986.71</td>
</tr>
<tr>
<td>Year 2 Estimated</td>
<td>Year 3 Estimated</td>
<td>Year 4 Estimated</td>
<td>Year 5 Estimated</td>
</tr>
<tr>
<td>Outcome Amount:</td>
<td>Outcome Amount:</td>
<td>Outcome Amount:</td>
<td>Outcome Amount:</td>
</tr>
<tr>
<td>$743,066.07</td>
<td>$743,066.07</td>
<td>$743,066.07</td>
<td>$743,066.07</td>
</tr>
<tr>
<td>$99,946.82</td>
<td>$99,946.82</td>
<td>$99,946.82</td>
<td>$99,946.82</td>
</tr>
<tr>
<td>$106,803.87</td>
<td>$106,803.87</td>
<td>$106,803.87</td>
<td>$106,803.87</td>
</tr>
<tr>
<td>$232,182.32</td>
<td>$232,182.32</td>
<td>$232,182.32</td>
<td>$232,182.32</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $481,999.08
Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Unique RHP outcome identification numbers: 113180703.3.20

Outcome Measure Description:
IT-6.1: Percent improvement over baseline of patient satisfaction scores
- Numerator: Percent improvement in CSQ8 scores
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served-determine process for data collection
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 6.1: Obtain a total average score for patients served of 2.5 or higher on the CSQ8 measure of patient satisfaction
- DY 5:
  - IT 6.1: Increase total average score for patients served on the CSQ8 measure of patient satisfaction by 25% over DY4

Rationale:
The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome.
This initiative will permit MHMRA, the performing provider, to improve on previous efforts to measure patient experience, through selection of reliable, valid measures with external benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain as measured by the CSQ-8.

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient experience is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Patients entering services will be given the CSQ-8 upon completion.

**Outcome Measure Valuation:**
Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe that if patients are satisfied with services received and communication with providers, they would be more willing to continue in ongoing services, thereby reducing preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>Related Category 1 or 2:</th>
<th>MHMRA of Harris County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent improvement over baseline of patient satisfaction scores</td>
<td>113180703</td>
</tr>
</tbody>
</table>

**Starting Point/Baseline:** Baseline will be in DY4, 321 patients expected to enter services in DY4

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1: P-1:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

**Metric 1:** Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information

**Data Source:** Meetings minutes, project flow charts and timelines

**Goal:** To integrate stakeholder input in development of program plan

**Milestone 6: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

**Metric 6:** Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information

**Data Source:** Meetings minutes, project flow charts and timelines

**Goal:** To complete project planning process and implement

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 11: IT 6-1 Percent improvement over baseline of patient satisfaction scores</strong></td>
<td><strong>Metric 12: IT 6-1 Percent improvement over baseline of patient satisfaction scores</strong></td>
</tr>
<tr>
<td>a. Numerator: Total average score of the CSQ8 measure of patient satisfaction</td>
<td>a. Numerator: Total average score of the CSQ8 measure of patient satisfaction</td>
</tr>
<tr>
<td>b. Denominator: Number of patients who were administered the survey</td>
<td>b. Denominator: Number of patients who were administered the survey</td>
</tr>
</tbody>
</table>

**Data Source:** CSQ8

**Goal:** obtain an average score of 2.5 or higher

**Estimated Incentive Payment:** $220,468.59

**Estimated Incentive Payment:** $121,182.34

**Estimated Incentive Payment:** $517,985.16

**Estimated Incentive Payment:** $500,468.75
<table>
<thead>
<tr>
<th>113180703.3.20</th>
<th>IT-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHMRA of Harris County</td>
<td>113180703</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2:</td>
<td>113180703.1.11</td>
<td></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>Baseline will be in DY4, 321 patients expected to enter services in DY4</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 2: P-2:</strong> Establish baseline</td>
<td><strong>Milestone 7: P-3:</strong> Develop and test data systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1:</strong> Identify domains of patient satisfaction to be measured</td>
<td><strong>Metric 1:</strong> Review satisfaction measures for use with the target population</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> literature review</td>
<td><strong>Data Source:</strong> Project record—summary of reviews, completed surveys</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> determine how baseline will be established for patient satisfaction domain</td>
<td><strong>Goal:</strong> Test and revise the selected instrument and/or process so that satisfaction patient satisfaction can be measured in DY4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $220,468.59</td>
<td><strong>Estimated Incentive Payment:</strong> $121,182.34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 3: P-3:</td>
<td>Milestone 8: P-9: Conduction Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 3:</strong> Review satisfaction measures for use with the target population and their clinical teams</td>
<td><strong>Metric 8:</strong> Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project record—summary of reviews</td>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> Identify/modify one instrument to test in Yr. 3</td>
<td><strong>Goal:</strong> To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Estimated Incentive Payment:** $220,468.59 | | **Estimated Incentive Payment:** $121,182.34 |

**Starting Point/Baseline:** Baseline will be in DY4, 321 patients expected to enter services in DY4
<table>
<thead>
<tr>
<th>Milestone 4: P-4:</th>
<th>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 4:</td>
<td>Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Goal:</td>
<td>To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>$220,468.59</td>
<td>Milestone 9: P-5: Disseminate findings to stakeholders</td>
</tr>
<tr>
<td>Metric 9:</td>
<td>Report status, progress and lessons learned to stakeholders</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Data Source:</td>
<td>management team minutes, RHP collaborations</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Goal:</td>
<td>To disseminate information about the project and solicit input from stakeholders</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>$121,182.34</td>
<td>Milestone 5: P-5: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
</tr>
<tr>
<td>Metric 5:</td>
<td>Report status, progress and lessons learned to stakeholders</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Data Source:</td>
<td>management team minutes, RHP collaborations</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Goal:</td>
<td>To disseminate information about the project and solicit input from stakeholders</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Estimated Incentive Payment: $220,468.59</td>
<td>Year 3 Estimated Outcome Amount: $484,729.36</td>
<td>Year 4 Estimated Outcome Amount: $517,985.16</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $19,441,204.66</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): IT-10.1: Functional Status

Unique RHP outcome identification numbers: 113180703.3.21

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Outcome Measure Description: IT-10.1: Demonstrate improvement in functional status
- Numerator: Percent improvement in functional status
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 5% over baseline scores.
- DY 5:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 10% over baseline scores.

Rationale:

The Adult Needs and Strengths Assessment (ANSA) is a multi-purpose tool developed to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. It has demonstrated reliability and validity. We propose to use the ANSA to measure aspects of functional status that are anticipated to show improvement through the expansion of outpatient mental health services. Specifically, the ANSA measures Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Family/Caregiver Strengths and Needs, Strengths,
Culture, Psychiatric Hospitalizations, Crisis History. Furthermore the ANSA has shown sensitivity to change in public mental health settings such as the proposed program.

In the initial year of serving patients in DY4, the patients will receive the ANSA at pre- and post completion of the CRU intervention. In DY 4, the goals for improvement from pre to post test ANSA scores have been set at 5% and 10% in DY 5. After the results of DY 4 have been determined, another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient outcomes. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified improved functional skills as measured by the ANSA (Adult Needs and Strengths Assessment), as a targeted outcome for outcome improvement goal because it measures patient benefits targeted through services offered in the outpatient setting proposed in this project. The ANSA-addresses a patient’s ability to function, providing evidence of the functional improvements expected to be seen by outpatient treatment. It is hypothesized that patients will be better served by providing ongoing outpatient treatment, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. Specifically, we believe that improved patient outcomes that include symptom reduction and improved functional status, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric and other inpatient facilities. If patients’ outcomes are not improved, it is more likely patients will disengage from services and may continue to over-utilize emergency services and inpatient care rather than engaging in preventive care. Since this patient outcome is proposed in conjunction with patient satisfaction as “stand-alone” measures, it will be valued at 50% of the Category 3 allocation for this proposed program.
<table>
<thead>
<tr>
<th>Related Category 1 or 2: 1.12.2</th>
<th>Outcome Measure: <strong>Functional Status</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RHP Performing Provider:</strong> Mental Health and Mental Retardation Authority of Harris County</td>
<td><strong>TPI:</strong> 113180703</td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong> Baseline will be in DY4, 321 patients expected to enter services in DY4</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1:</strong> <strong>P-1:</strong> Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 6:</strong> <strong>P-1:</strong> Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 11:</strong> IT-10.1 Percent improvement over baseline of patient functional status scores</td>
<td><strong>Milestone 12:</strong> IT-10.1 Percent improvement over baseline of patient functional status scores</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source:</strong> ANSA</td>
<td><strong>Data Source:</strong> ANSA</td>
</tr>
<tr>
<td><strong>Goal:</strong> To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way</td>
<td><strong>Goal:</strong> To complete project planning process and implement</td>
<td><strong>Goal:</strong> 5% increase of post test scores over pre-test scores in at least one domain of the ANSA</td>
<td><strong>Goal:</strong> 10% increase of post test scores over pre-test scores in at least one domain of the ANSA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Estimated Incentive Payment:</strong> $220,468.59</th>
<th><strong>Estimated Incentive Payment:</strong> $121,182.34</th>
<th><strong>Estimated Incentive Payment:</strong> $517,985.16</th>
<th><strong>Estimated Incentive Payment:</strong> $500,468.75</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 2:</strong> <strong>P-2:</strong> Establish baseline</td>
<td><strong>Milestone 7:</strong> <strong>P-3:</strong> Develop and test data systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> literature review</td>
<td><strong>Data Source:</strong> Project record—summary of reviews, completed surveys</td>
<td><strong>Goal:</strong> Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3</td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> determine how baseline will be established for patient satisfaction domain</td>
<td><strong>Goal:</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Estimated Incentive Payment:</strong> $220,468.59</th>
<th><strong>Estimated Incentive Payment:</strong> $121,182.34</th>
<th></th>
<th></th>
</tr>
</thead>
</table>

Regional Healthcare Partnership Plan
Region 3

Estimated Incentive Payment: $220,468.59

Estimated Incentive Payment: $121,182.34

Estimated Incentive Payment: $517,985.16

Estimated Incentive Payment: $500,468.75
<table>
<thead>
<tr>
<th>Year</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 3: P-3:</strong></td>
<td>Develop and test data systems</td>
<td><strong>Milestone 8: P-4:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td><strong>Milestone 9: P-5:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Milestone 9: P-5:</strong> Disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td>Project record—summary of reviews</td>
<td><strong>Data Source:</strong> Project reports, QI reports</td>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
</tr>
<tr>
<td><strong>Goal:</strong></td>
<td>Identify/modify one instrument to test in Yr. 3</td>
<td><strong>Goal:</strong> To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment:**
- Year 2: $220,468.59
- Year 3: $121,182.34
- Year 4: $220,468.59
- Year 5: $121,182.34
<table>
<thead>
<tr>
<th>Related Category 1 or 2:</th>
<th>1.12.2</th>
<th>Outcome Measure: <strong>Functional Status</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td>TPI: 113180703</td>
<td></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>Baseline will be in DY4, 321 patients expected to enter services in DY4</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Milestone 5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders</strong></td>
<td><strong>Data Source:</strong> minutes from stakeholder meetings</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $220,468.59</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $1,102,342.97</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $484,729.36</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $517,985.16</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $19,441,204.66</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Title of Outcome Measure (Improvement Target):** IT-10.1: Functional Status

**Unique RHP outcome identification numbers:** 113180703.3.22

**Performing Provider/TPI:** Mental Health and Mental Retardation Authority of Harris County/ 113180703

**Outcome Measure Description:** IT-10.1: Demonstrate improvement in functional status
- Numerator: Percent improvement in functional status
- Denominator: Number of patients who were administered the survey

**Process Milestones:**
- **DY 2:**
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- **DY 3:**
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

**Outcome Improvement Targets for each year:**
- **DY 4:**
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 5% over baseline scores.
- **DY 5:**
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 10% over baseline scores.

**Rationale:**

The **Adult Needs and Strengths Assessment (ANSA)** is a multi-purpose tool developed to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. It has demonstrated reliability and validity. We propose to use the ANSA to measure aspects of functional status that are expected to improve as a result of the expansion of outpatient mental health services. Specifically, the ANSA measures Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Family/Caregiver Strengths and Needs, Strengths, Culture, Psychiatric Hospitalizations, Crisis History. Furthermore the ANSA has shown sensitivity to
change in public mental health settings such as the proposed program.

From an initial baseline to be conducted in DY 3, the goals for improvement in ANSA scores have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined, another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient outcomes. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified improved functional skills as measured by the ANSA (Adult Needs and Strengths Assessment), as a targeted outcome for outcome improvement goal because it measures patient benefits targeted through services offered in the outpatient setting proposed in this project. The ANSA addresses a patient’s ability to function, providing evidence of the functional improvements expected to be seen by outpatient treatment. It is hypothesized that patients will be better served by providing ongoing outpatient treatment, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. Specifically, we believe that improved patient outcomes that include symptom reduction and improved functional status, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric and other inpatient facilities. If patients’ outcomes are not improved, it is more likely patients will disengage from services and may continue to over-utilize emergency services and inpatient care rather than engaging in preventive care. Since this patient outcome is proposed in conjunction with patient satisfaction as “stand-alone” measures, it will be valued at 50% of the Category 3 allocation for this proposed program.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
| **Milestone 1: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
 **Data Source:** Meetings minutes, project flow charts and timelines  
 **Goal:** To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way | **Milestone 6: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
 **Data Source:** Meetings minutes, project flow charts and timelines  
 **Goal:** To complete project planning process and implement | **Milestone 11:** IT-10.1 Percent improvement over baseline of patient functional status scores  
 **Data Source:** ANSA  
 **Goal:** 5% increase over baseline in at least one domain of the ANSA | **Milestone 12:** IT-10.1 Percent improvement over baseline of patient functional status scores  
 **Data Source:** ANSA  
 **Goal:** 10% increase in baseline in at least one domain of the ANSA |
| Estimated Incentive Payment: $15,719.30 | Estimated Incentive Payment: $36,481.00 | Estimated Incentive Payment: $194,919.26 | Estimated Incentive Payment: $423,737.53 |

**Milestone 2: P-2:** Establish baseline  
**Data Source:** literature review  
**Goal:** determine how baseline will be established for patient satisfaction domain

**Milestone 7: P-2:** Establish baseline  
**Data Source:** Clinical records; monthly management reports  
**Goal:** obtain baseline of functional status (using the ANSA) from patients receiving service in DY3 (250 estimated)

**Estimated Incentive Payment:** $15,719.30 **Estimated Incentive Payment:** $36,481.00
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County

Outcome Measure: **Functional Status**

RHP: 113180703

**Related Category 1 or 2:** 113180703.1.1

**Starting Point/Baseline:** Baseline will be collected in DY3 from the 250 patients expected to be served that DY

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
| **Milestone 3: P-3:** Develop and test data systems  
**Data Source:** Project record—summary of reviews  
**Goal:** Identify/modify one instrument to test in Yr. 3 | **Milestone 4: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Data Source:** Project reports, QI reports  
**Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations | **Milestone 8: P-3:** Develop and test data systems  
**Data Source:** Project record—summary of reviews, completed surveys  
**Goal:** Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3 | **Milestone 9: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Data Source:** Project reports, QI reports  
**Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations |

**Estimated Incentive Payment:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
| **$15,719.30** | **Estimated Incentive Payment:**  
**$36,481.00** | **Estimated Incentive Payment:**  
**$15,719.30** | **Estimated Incentive Payment:**  
**$36,481.00** |
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 5: P-5</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Milestone 10: P-5</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> minutes from stakeholder meetings</td>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Incentive Payment: $15,719.30</td>
<td>Estimated Incentive Payment: $36,481.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $78,596.48</td>
<td>Year 3 Estimated Outcome Amount: $182,405.01</td>
<td>Year 4 Estimated Outcome Amount: $194,919.26</td>
<td>Year 5 Estimated Outcome Amount: $423,737.53</td>
</tr>
<tr>
<td><strong>TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY:</strong> $879,658.28</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Title of Outcome Measure (Improvement Target):** IT-9.4: Other outcome improvement target: Percent decrease in psychiatric symptoms that provoke behavioral crises

**Unique RHP outcome identification numbers:** 113180703.3.23

**Performing Provider/TPI:** Mental Health and Mental Retardation Authority of Harris County/113180703

**Outcome Measure Description:** IT-9.4: Percent improvement over baseline of patient psychiatric symptoms using the Reiss Screen for Maladaptive Behavior
- Numerator: Average change in Reiss score across patients
- Denominator: Average prior score across patients

**Process Milestones:**
- **DY 2:**
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders
- **DY 3:**
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders

**Outcome Improvement Targets for each year:**
- **DY 4:**
  - IT 6.1: Rate 2: Improve patient psychiatric symptoms by 5% over baseline scores for one domain of patient symptoms
- **DY 5:**
  - IT 6.1: Rate 2: Improve patient psychiatric symptoms by 10% over baseline scores for one domain of patient symptoms

**Rationale:**
The primary function of an outpatient clinic is to reduce the behavioral/psychiatric symptoms that provoke behavioral crises and result in inappropriate care in settings such as emergency departments, inpatient psychiatric units and jails. This function is challenging for clinics that are unfamiliar with the target population and that are not familiar with well-established, evidence-based measures to evaluate progress. The proposed program is skilled in treating the target population and has selected the Reiss Screen for Maladaptive Behaviors to evaluate treatment outcomes. The Reiss Screen has been used extensively in research and clinical settings and is
nationwide normed on the target population of people with IDD/ASD and co-occurring mental illness. The Reiss Screen is available for children and adults, allowing uniformity in how all of the program’s patients will be assessed.

Upon intake, each patient will be assessed on the Reiss Screen to establish baseline levels of symptoms. Patients will be reevaluated at 3 months, 6 months and 12 months to track progress. From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient clinical progress. This information can then be provided to clinic staff in order to modify treatment goals and interventions as needed.

**Outcome Measure Valuation:**

Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-9 Right Care, Right Setting, IT-9.4: Other outcome improvement target: Percent decrease in psychiatric symptoms that provoke behavioral crises. It is hypothesized, and supported by research literature, that patients with co-occurring IDD/ASD are often treated in settings that do not match their needs, by well-meaning clinicians who are not skilled in the IDD/ASD behavioral specialty. The mismatch between need and treatment results in poor clinical outcomes and utilization of inappropriate resources, such as emergency rooms, inpatient hospital units and jails. Access to competent outpatient care that promotes and demonstrates amelioration of symptoms is expected to result in benefits for the patient and the patient’s family, and result in overall savings for a healthcare system that will not be utilizing funds ineffectively in response to repeated crises.
### Related Category 1 or 2: 1.9

#### Starting Point/Baseline:
Baseline will be taken in DY 3 with about 150 anticipated patients

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Milestone 1** P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
**Data Source:** Meetings minutes, project flow charts and timelines  
**Goal:** To integrate stakeholder input in development of program plan  
**Estimated Incentive Payment:** $7,990.49 | **Milestone 6:** P-1: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
**Data Source:** Meetings minutes, project flow charts and timelines  
**Goal:** To complete project planning process and implement  
**Estimated Incentive Payment:** $18,644.16 | **Milestone 11:** IT 6.1 Percent improvement over baseline of patient psychiatric symptoms as measured by the REISS.  
**Data Source:** REISS  
**Goal:** 5% increase over baseline  
**Estimated Incentive Payment:** $99,582.11 | **Milestone 12:** IT 6.1 Percent improvement over baseline of patient psychiatric symptoms as measured by the REISS.  
**Data Source:** REISS  
**Goal:** 10% increase in baseline  
**Estimated Incentive Payment:** $215,895.89 |
| **Milestone 2** P-2: Establish baseline  
**Data Source:** literature review  
**Goal:** determine how baseline will be established for patient satisfaction domain  
**Estimated Incentive Payment:** $7,990.49 | **Milestone 7** P-2: Establish baseline  
**Data Source:** Clinical records; monthly management reports  
**Goal:** obtain baseline of satisfaction survey from patients receiving service  
**Estimated Incentive Payment:** $18,644.16 |  |  |
| **Milestone 3** P-3: Develop and test data systems  
**Data Source:** Project record—summary of reviews  
**Goal:** Identify/modify one instrument to test in Yr. 3  
**Estimated Incentive Payment:** $7,990.49 | **Milestone 8** P-3 Develop and test data systems  
**Data Source:** Project record—summary of reviews, completed surveys  
**Goal:** Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3  
**Estimated Incentive Payment:** $18,644.16 |  |  |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</strong></td>
<td><strong>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</strong></td>
<td><strong>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</strong></td>
<td><strong>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</strong></td>
<td><strong>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</strong></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
</tr>
<tr>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $7,990.49</td>
<td><strong>Estimated Incentive Payment:</strong> $18,644.16</td>
<td><strong>Estimated Incentive Payment:</strong> $18,644.16</td>
<td><strong>Estimated Incentive Payment:</strong> $18,644.16</td>
<td><strong>Estimated Incentive Payment:</strong> $18,644.16</td>
</tr>
</tbody>
</table>

**Milestone 5: P-5** Disseminate findings, including lessons learned and best practices, to stakeholders
**Metric 5:** Report status, progress and lessons learned to stakeholders
**Data Source:** management team minutes, RHP collaborations
**Goal:** To disseminate information about the project and solicit input from stakeholders

**Estimated Incentive Payment:** $7,990.49

**Milestone 10: P.10:** Disseminate findings to stakeholders
**Metric 10:** Report status, progress and lessons learned to stakeholders
**Data Source:** management team minutes, RHP collaborations
**Goal:** To disseminate information about the project and solicit input from stakeholders

**Estimated Incentive Payment:** $18,644.16
<table>
<thead>
<tr>
<th>Related Category 1 or 2:</th>
<th>MHMRA of Harris County</th>
<th>TPI: 113180703</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be taken in DY 3 with about 150 anticipated patients</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: $39,952.46</td>
<td>Year 3 Estimated Outcome Amount: $93,220.82</td>
<td>Year 4 Estimated Outcome Amount: $99,582.11</td>
<td>Year 5 Estimated Outcome Amount: $215,895.89</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $448,651.28
Title of Outcome Measure (Improvement Target): IT-10.1: Functional Status

Unique RHP outcome identification numbers: 113180703.3.24
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Outcome Measure Description: IT-10.1: Demonstrate improvement in functional status
- Numerator: Percent improvement in functional status
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 5% over baseline scores.
- DY 5:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 10% over baseline scores.

Rationale:

The Adult Needs and Strengths Assessment (ANSA) is a multi-purpose tool developed to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. It has demonstrated reliability and validity. We propose to use the ANSA to measure aspects of functional status that are anticipated to show improvement through the expansion of outpatient mental health services. Specifically, the ANSA measures Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Family/Caregiver Strengths and Needs, Strengths, Culture, Psychiatric Hospitalizations, Crisis History. Furthermore the ANSA has shown sensitivity to change in public mental health settings such as the proposed program.
From an initial baseline to be conducted in DY 3, the goals for improvement in ANSA scores have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined, another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient outcomes. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified improved functional skills as measured by the ANSA (Adult Needs and Strengths Assessment), as a targeted outcome for outcome improvement goal because it measures patient benefits targeted through services offered in the outpatient setting proposed in this project. The ANSA-addresses a patient’s ability to function, providing evidence of the functional improvements expected to be seen by outpatient treatment. It is hypothesized that patients will be better served by providing ongoing outpatient treatment, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. Specifically, we believe that improved patient outcomes that include symptom reduction and improved functional status, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric and other inpatient facilities. If patients’ outcomes are not improved, it is more likely patients will disengage from services and may continue to over-utilize emergency services and inpatient care rather than engaging in preventive care. Since this patient outcome is proposed in conjunction with patient satisfaction as “stand-alone” measures, it will be valued at 50% of the Category 3 allocation for this proposed program.
<table>
<thead>
<tr>
<th>Milestone 1: P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Milestone 6: P-1: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Milestone 11: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
<th>Milestone 12: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Meetings minutes, project flow charts and timelines</td>
<td>Data Source: Meetings minutes, project flow charts and timelines</td>
<td>Data Source: ANSA</td>
<td>Data Source: ANSA</td>
</tr>
<tr>
<td>Goal: To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way</td>
<td>Goal: To complete project planning process and implement</td>
<td>Goal: 5% increase over baseline in at least one domain of the ANSA</td>
<td>Goal: 10% increase in baseline in at least one domain of the ANSA</td>
</tr>
<tr>
<td>Estimated Incentive Payment: $15,719.30</td>
<td>Estimated Incentive Payment: $36,481.00</td>
<td>Estimated Incentive Payment: $194,919.26</td>
<td>Estimated Incentive Payment: $423,737.53</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 2: P-2: Establish baseline</th>
<th>Milestone 7: P-2: Establish baseline</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: literature review</td>
<td>Data Source: Clinical records; monthly management reports</td>
<td></td>
</tr>
<tr>
<td>Goal: determine how baseline will be established for patient satisfaction domain</td>
<td>Goal: obtain baseline of satisfaction survey from patients receiving service</td>
<td></td>
</tr>
<tr>
<td>Estimated Incentive Payment: $15,719.30</td>
<td>Estimated Incentive Payment: $36,481.00</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 3 : P-3: Develop and test data systems</th>
<th>Milestone 8: P-3: Develop and test data systems</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Project record—summary of reviews</td>
<td>Data Source: Project record—summary of reviews, completed surveys</td>
<td></td>
</tr>
<tr>
<td>Goal: Identify/modify one instrument to test in Yr. 3</td>
<td>Goal: Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3</td>
<td></td>
</tr>
</tbody>
</table>
### Outcome Measure: Functional Status

<table>
<thead>
<tr>
<th>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</th>
<th>TPI: 113180703</th>
</tr>
</thead>
</table>

**Related Category 1 or 2: 1.12.2**

**Starting Point/Baseline:** Baseline will be collected in DY3 from the 250 patients expected to be served that DY

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>

**Estimated Incentive Payment:** $15,719.30

**Milestone 4: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

- **Data Source:** Project reports, QI reports
- **Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations

**Estimated Incentive Payment:** $36,481.00

**Milestone 9: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

- **Data Source:** Project reports, QI reports
- **Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations

**Estimated Incentive Payment:** $15,719.30

**Milestone 5: P-5:** Disseminate findings, including lessons learned and best practices, to stakeholders

- **Data Source:** minutes from stakeholder meetings
- **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers

**Estimated Incentive Payment:** $36,481.00

**Milestone 10: P-5:** Disseminate findings, including lessons learned and best practices, to stakeholders

- **Data Source:** management team minutes, RHP collaborations
- **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers

**Estimated Incentive Payment:** $15,719.30

**Estimated Incentive Payment:** $36,481.00
<table>
<thead>
<tr>
<th>Year 2 Baseline</th>
<th>Year 3 Baseline</th>
<th>Year 4 Baseline</th>
<th>Year 5 Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: $78,596.48</td>
<td>Year 3 Estimated Outcome Amount: $182,405.01</td>
<td>Year 4 Estimated Outcome Amount: $194,919.26</td>
<td>Year 5 Estimated Outcome Amount: $423,737.53</td>
</tr>
</tbody>
</table>

TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY: $879,658.28
Title of Outcome Measure (Improvement Target): IT-10.1: Functional Status

Unique RHP outcome identification numbers: 113180703.3.25

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Outcome Measure Description: IT-10.1: Demonstrate improvement in functional status
- Numerator: Percent improvement in functional status
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 5 % over baseline scores.
- DY 5:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 10 % over baseline scores.

Rationale:

The Adult Needs and Strengths Assessment (ANSA) is a multi-purpose tool developed to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. It has demonstrated reliability and validity. We propose to use the ANSA to measure aspects of functional status that are anticipated to show improvement through the expansion of outpatient mental health services. Specifically, the ANSA measures Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Family/Caregiver Strengths and Needs, Strengths, Culture, Psychiatric Hospitalizations, Crisis History. Furthermore the ANSA has shown
sensitivity to change in public mental health settings such as the proposed program.

From an initial baseline to be conducted in DY 3, the goals for improvement in ANSA scores have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined, another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient outcomes. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified improved functional skills as measured by the ANSA (Adult Needs and Strengths Assessment), as a targeted outcome for outcome improvement goal because it measures patient benefits targeted through services offered in the outpatient setting proposed in this project. The ANSA-addresses a patient’s ability to function, providing evidence of the functional improvements expected to be seen by outpatient treatment. It is hypothesized that patients will be better served by providing ongoing outpatient treatment, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. Specifically, we believe that improved patient outcomes that include symptom reduction and improved functional status, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric and other inpatient facilities. If patients’ outcomes are not improved, it is more likely patients will disengage from services and may continue to over-utilize emergency services and inpatient care rather than engaging in preventive care.
<table>
<thead>
<tr>
<th>Milestone 1: P-1: Project planning</th>
<th>Milestone 6: P-1: Project planning</th>
<th>Milestone 11: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
<th>Milestone 12: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>IT-10.1 Percent improvement over baseline of patient functional status scores</td>
<td>IT-10.1 Percent improvement over baseline of patient functional status scores</td>
</tr>
<tr>
<td>Data Source: Meetings minutes, project flow charts and timelines</td>
<td>Data Source: Meetings minutes, project flow charts and timelines</td>
<td>Data Source: ANSA</td>
<td>Data Source: ANSA</td>
</tr>
<tr>
<td>Goal: To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way</td>
<td>Goal: To complete project planning process and implement</td>
<td>Goal: 5% increase over baseline in at least one domain of the ANSA</td>
<td>Goal: 10% increase in baseline in at least one domain of the ANSA</td>
</tr>
</tbody>
</table>

**Starting Point/Baseline:** Baseline will be collected in DY3 from the 250 patients expected to be served that DY

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 2: P-2: Establish baseline</td>
<td>Milestone 7: P-2: Establish baseline</td>
<td>Milestone 11: IT-10.1 Percent improvement over baseline of patient functional status scores</td>
<td>Milestone 12: IT-10.1 Percent improvement over baseline of patient functional status scores</td>
</tr>
<tr>
<td>Data Source: literature review</td>
<td>Data Source: Clinical records; monthly management reports</td>
<td>Data Source: ANSA</td>
<td>Data Source: ANSA</td>
</tr>
<tr>
<td>Goal: determine how baseline will be established for patient satisfaction domain</td>
<td>Goal: obtain baseline of satisfaction survey from patients receiving service</td>
<td>Goal: 5% increase over baseline in at least one domain of the ANSA</td>
<td>Goal: 10% increase in baseline in at least one domain of the ANSA</td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment:**

- Year 2: $15,719.30
- Year 3: $36,481.00
- Year 4: $194,919.26
- Year 5: $423,737.53
**Outcome Measure:** Functional Status

RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County  
TPI: 113180703

### Related Category 1 or 2: 1.12.2

113180703.1.5

### Starting Point/Baseline:

Baseline will be collected in DY3 from the 250 patients expected to be served that DY

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 3: P-3:** Develop and test data systems

**Data Source:** Project record—summary of reviews  
**Goal:** Identify/modify one instrument to test in Yr. 3

**Estimated Incentive Payment:** $15,719.30

**Milestone 8: P-3:** Develop and test data systems

**Data Source:** Project record—summary of reviews, completed surveys  
**Goal:** Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3

**Estimated Incentive Payment:** $36,481.00

**Milestone 4: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

**Data Source:** Project reports, QI reports  
**Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations

**Estimated Incentive Payment:** $15,719.30

**Milestone 9: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

**Data Source:** Project reports, QI reports  
**Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations

**Estimated Incentive Payment:** $36,481.00

N/A

N/A

N/A

N/A
<table>
<thead>
<tr>
<th>Related Category 1 or 2: 1.12.2</th>
<th>113180703.1.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be collected in DY3 from the 250 patients expected to be served that DY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 5: P-5</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Milestone 10: P-5</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Data Source:</strong> minutes from stakeholder meetings</td>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $15,719.30</td>
<td><strong>Estimated Incentive Payment:</strong> $36,481.00</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $78,596.48</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $182,405.01</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $194,919.26</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $423,737.53</td>
</tr>
</tbody>
</table>

**TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY:** $879,658.28
Title of Outcome Measure (Improvement Target): IT-10.1: Functional Status

Unique RHP outcome identification numbers: 113180703.3.26

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Outcome Measure Description: IT-10.1: Demonstrate improvement in functional status

- Numerator: Percent improvement in functional status
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 5 % over baseline scores.

- DY 5:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 10 % over baseline scores.

Rationale:

The Adult Needs and Strengths Assessment (ANSA) is a multi-purpose tool developed to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. It has demonstrated reliability and validity. We propose to use the ANSA to measure aspects of functional status that are anticipated to show improvement through the expansion of outpatient mental health services. Specifically, the ANSA measures Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Family/Caregiver Strengths and Needs, Strengths, Culture, Psychiatric Hospitalizations, Crisis History. Furthermore the ANSA has shown
sensitivity to change in public mental health settings such as the proposed program.

From an initial baseline to be conducted in DY 3, the goals for improvement in ANSA scores have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined, another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient outcomes. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified improved functional skills as measured by the ANSA (Adult Needs and Strengths Assessment), as a targeted outcome for outcome improvement goal because it measures patient benefits targeted through services offered in the outpatient setting proposed in this project. The ANSA-addresses a patient’s ability to function, providing evidence of the functional improvements expected to be seen by outpatient treatment. It is hypothesized that patients will be better served by providing ongoing outpatient treatment, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. Specifically, we believe that improved patient outcomes that include symptom reduction and improved functional status, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric and other inpatient facilities. If patients’ outcomes are not improved, it is more likely patients will disengage from services and may continue to over-utilize emergency services and inpatient care rather than engaging in preventive care.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1: P-1</strong>: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 6: P-1</strong>: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 11: IT-10.1</strong> Percent improvement over baseline of patient functional status scores</td>
<td><strong>Milestone 12: IT-10.1</strong> Percent improvement over baseline of patient functional status scores</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source</strong>: Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source</strong>: ANSA</td>
<td><strong>Data Source</strong>: ANSA</td>
</tr>
<tr>
<td><strong>Goal</strong>: To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way</td>
<td><strong>Goal</strong>: To complete project planning process and implement</td>
<td><strong>Goal</strong>: 5% increase over baseline in at least one domain of the ANSA</td>
<td><strong>Goal</strong>: 10% increase in baseline in at least one domain of the ANSA</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment</strong>: $15,719.30</td>
<td><strong>Estimated Incentive Payment</strong>: $36,481.00</td>
<td><strong>Estimated Incentive Payment</strong>: $194,919.26</td>
<td><strong>Estimated Incentive Payment</strong>: $423,737.53</td>
</tr>
</tbody>
</table>

**Milestone 2: P-2**: Establish baseline

**Data Source**: literature review
**Goal**: determine how baseline will be established for patient satisfaction domain

**Estimated Incentive Payment**: $15,719.30

<table>
<thead>
<tr>
<th>Year 7 (10/1/2016 – 9/30/2017)</th>
<th>Year 8 (10/1/2017 – 9/30/2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 13: P-1</strong> Percent improvement over baseline of patient functional status scores</td>
<td><strong>Milestone 14: P-1</strong> Percent improvement over baseline of patient functional status scores</td>
</tr>
<tr>
<td><strong>Data Source</strong>: ANSA</td>
<td><strong>Data Source</strong>: ANSA</td>
</tr>
<tr>
<td><strong>Goal</strong>: 15% increase in baseline in at least one domain of the ANSA</td>
<td><strong>Goal</strong>: 20% increase in baseline in at least one domain of the ANSA</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment</strong>: $216,647.25</td>
<td><strong>Estimated Incentive Payment</strong>: $377,484.00</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td><strong>Milestone 3: P-3:</strong> Develop and test data systems</td>
<td><strong>Milestone 8: P-3:</strong> Develop and test data systems</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project record—summary of reviews</td>
<td><strong>Data Source:</strong> Project record—summary of reviews, completed surveys</td>
</tr>
<tr>
<td><strong>Goal:</strong> Identify/modify one instrument to test in Yr. 3</td>
<td><strong>Goal:</strong> Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $15,719.30</td>
<td><strong>Estimated Incentive Payment:</strong> $36,481.00</td>
</tr>
<tr>
<td><strong>Milestone 4: P-4:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td><strong>Milestone 9: P-4:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project reports, QI reports</td>
<td><strong>Data Source:</strong> Project reports, QI reports</td>
</tr>
<tr>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $15,719.30</td>
<td><strong>Estimated Incentive Payment:</strong> $36,481.00</td>
</tr>
<tr>
<td>Related Category 1 or 2: 1.12.2</td>
<td>113180703.1.6</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be collected in DY3 from the 250 patients expected to be served that DY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 5:</strong> P-5 Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Milestone 10:</strong> P-5: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
</tr>
<tr>
<td><strong>Data Source:</strong> minutes from stakeholder meetings</td>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $15,719.30</td>
<td><strong>Estimated Incentive Payment:</strong> $36,481.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $78,596.48</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $182,405.01</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $194,919.26</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $423,737.53</td>
</tr>
<tr>
<td><strong>TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY:</strong></td>
<td>$879,658.28</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Outcome Measure: **Functional Status**

RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County

TPI: 113180703
Title of Outcome Measure (Improvement Target): IT-10.1: Functional Status

Unique RHP outcome identification numbers: 113180703.3.27

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Outcome Measure Description: IT-10.1: Demonstrate improvement in functional status
- Numerator: Percent improvement in functional status
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 5% over baseline scores.
- DY 5:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 10% over baseline scores.

Rationale:

The Adult Needs and Strengths Assessment (ANSA) is a multi-purpose tool developed to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. It has demonstrated reliability and validity. We propose to use the ANSA to measure aspects of functional status that are anticipated to show improvement through the expansion of outpatient mental health services. Specifically, the ANSA measures Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Family/Caregiver Strengths and Needs, Strengths,
Culture, Psychiatric Hospitalizations, Crisis History. Furthermore the ANSA has shown sensitivity to change in public mental health settings such as the proposed program.

From an initial baseline to be conducted in DY 3, the goals for improvement in ANSA scores have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined, another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient outcomes. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified improved functional skills as measured by the ANSA (Adult Needs and Strengths Assessment), as a targeted outcome for outcome improvement goal because it measures patient benefits targeted through services offered in the outpatient setting proposed in this project. The ANSA-addresses a patient’s ability to function, providing evidence of the functional improvements expected to be seen by outpatient treatment. It is hypothesized that patients will be better served by providing ongoing outpatient treatment, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. Specifically, we believe that improved patient outcomes that include symptom reduction and improved functional status, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric and other inpatient facilities. If patients’ outcomes are not improved, it is more likely patients will disengage from services and may continue to over-utilize emergency services and inpatient care rather than engaging in preventive care. Since this patient outcome is proposed in conjunction with patient satisfaction as “stand-alone” measures, it will be valued at 50% of the Category 3 allocation for this proposed program.
## Outcome Measure: Functional Status

<table>
<thead>
<tr>
<th>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</th>
<th>TPI: 113180703</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2: 1.12.2</td>
<td>113180703.1.7</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be collected in DY3 from the 250 patients expected to be served that DY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1: P-1:</strong> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 6: P-1:</strong> Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 11:</strong> IT-10.1 Percent improvement over baseline of patient functional status scores</td>
<td><strong>Milestone 12:</strong> IT-10.1 Percent improvement over baseline of patient functional status scores</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source:</strong> ANSA</td>
<td><strong>Data Source:</strong> ANSA</td>
</tr>
<tr>
<td><strong>Goal:</strong> To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way</td>
<td><strong>Goal:</strong> To complete project planning process and implement</td>
<td><strong>Goal:</strong> 5% increase over baseline in at least one domain of the ANSA</td>
<td><strong>Goal:</strong> 10% increase in baseline in at least one domain of the ANSA</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $15,719.30</td>
<td><strong>Estimated Incentive Payment:</strong> $36,481.00</td>
<td><strong>Estimated Incentive Payment:</strong> $194,919.26</td>
<td><strong>Estimated Incentive Payment:</strong> $423,737.53</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 2: P-2: Establish baseline</th>
<th>Milestone 7: P-2: Establish baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong> literature review</td>
<td><strong>Data Source:</strong> Clinical records; monthly management reports</td>
</tr>
<tr>
<td><strong>Goal:</strong> determine how baseline will be established for patient satisfaction domain</td>
<td><strong>Goal:</strong> obtain baseline of satisfaction survey from patients receiving service</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $15,719.30</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 11: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
<th>Milestone 12: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong> ANSA</td>
<td><strong>Data Source:</strong> ANSA</td>
</tr>
<tr>
<td><strong>Goal:</strong> 5% increase over baseline in at least one domain of the ANSA</td>
<td><strong>Goal:</strong> 10% increase in baseline in at least one domain of the ANSA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 11: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
<th>Milestone 12: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong> ANSA</td>
<td><strong>Data Source:</strong> ANSA</td>
</tr>
<tr>
<td><strong>Goal:</strong> 5% increase over baseline in at least one domain of the ANSA</td>
<td><strong>Goal:</strong> 10% increase in baseline in at least one domain of the ANSA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 11: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
<th>Milestone 12: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong> ANSA</td>
<td><strong>Data Source:</strong> ANSA</td>
</tr>
<tr>
<td><strong>Goal:</strong> 5% increase over baseline in at least one domain of the ANSA</td>
<td><strong>Goal:</strong> 10% increase in baseline in at least one domain of the ANSA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 11: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
<th>Milestone 12: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong> ANSA</td>
<td><strong>Data Source:</strong> ANSA</td>
</tr>
<tr>
<td><strong>Goal:</strong> 5% increase over baseline in at least one domain of the ANSA</td>
<td><strong>Goal:</strong> 10% increase in baseline in at least one domain of the ANSA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 11: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
<th>Milestone 12: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong> ANSA</td>
<td><strong>Data Source:</strong> ANSA</td>
</tr>
<tr>
<td><strong>Goal:</strong> 5% increase over baseline in at least one domain of the ANSA</td>
<td><strong>Goal:</strong> 10% increase in baseline in at least one domain of the ANSA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 11: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
<th>Milestone 12: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong> ANSA</td>
<td><strong>Data Source:</strong> ANSA</td>
</tr>
<tr>
<td><strong>Goal:</strong> 5% increase over baseline in at least one domain of the ANSA</td>
<td><strong>Goal:</strong> 10% increase in baseline in at least one domain of the ANSA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 11: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
<th>Milestone 12: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong> ANSA</td>
<td><strong>Data Source:</strong> ANSA</td>
</tr>
<tr>
<td><strong>Goal:</strong> 5% increase over baseline in at least one domain of the ANSA</td>
<td><strong>Goal:</strong> 10% increase in baseline in at least one domain of the ANSA</td>
</tr>
<tr>
<td>Year</td>
<td>Base Line or Baseline</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Baseline will be collected in DY3 from the 250 patients expected to be served that DY</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project record—summary of reviews</td>
<td><strong>Data Source:</strong> Project record—summary of reviews, completed surveys</td>
</tr>
<tr>
<td><strong>Goal:</strong> Identify/modify one instrument to test in Yr. 3</td>
<td><strong>Goal:</strong></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $15,719.30</td>
<td><strong>Estimated Incentive Payment:</strong> $36,481.00</td>
</tr>
<tr>
<td>Milestone 4: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>Milestone 9: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project reports, QI reports</td>
<td><strong>Data Source:</strong> Project reports, QI reports</td>
</tr>
<tr>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $15,719.30</td>
<td><strong>Estimated Incentive Payment:</strong> $36,481.00</td>
</tr>
<tr>
<td>Year</td>
<td>Milestone 5: P-5</td>
</tr>
<tr>
<td>------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Year 2</td>
<td>Disseminate findings, including lessons learned and best practices, to stakeholders</td>
</tr>
<tr>
<td>(10/1/2012 – 9/30/2013)</td>
<td><strong>Data Source:</strong> minutes from stakeholder meetings</td>
</tr>
<tr>
<td>Year 3</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
</tr>
<tr>
<td>(10/1/2013 – 9/30/2014)</td>
<td>Estimated Incentive Payment: $15,719.30</td>
</tr>
<tr>
<td>Year 4</td>
<td>Year 3 Estimated Outcome Amount: $182,405.01</td>
</tr>
<tr>
<td>(10/1/2014 – 9/30/2015)</td>
<td>Year 5 Estimated Outcome Amount: $423,737.53</td>
</tr>
<tr>
<td>Year 5</td>
<td>TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY: $879,658.28</td>
</tr>
<tr>
<td>(10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
</tbody>
</table>
**Title of Outcome Measure (Improvement Target):** IT-10.1: Functional Status

**Unique RHP outcome identification numbers:** 113180703.3.30

**Performing Provider/TPI:** Mental Health and Mental Retardation Authority of Harris County/113180703

**Outcome Measure Description:** IT-10.1: Demonstrate improvement in functional status
- Numerator: Percent improvement in functional status
- Denominator: Number of patients who were administered the survey

**Process Milestones:**
- **DY 2:**
  - P-1- Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- **DY 3:**
  - P-1- Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

**Outcome Improvement Targets for each year:**
- **DY 4:**
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 5% over baseline scores.
- **DY 5:**
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 10% over baseline scores.

**Rationale:**

The **Adult Needs and Strengths Assessment (ANSA)** is a multi-purpose tool developed to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. It has demonstrated reliability and validity. We propose to use the ANSA to measure aspects of functional status that are anticipated to show improvement through the expansion of outpatient mental health services. Specifically, the ANSA measures Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Family/Caregiver Strengths and Needs, Strengths, Culture, Psychiatric Hospitalizations, Crisis History. Furthermore the ANSA has shown
sensitivity to change in public mental health settings such as the proposed program.

From an initial baseline to be conducted in DY 3, the goals for improvement in ANSA scores have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined, another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient outcomes. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified improved functional skills as measured by the ANSA (Adult Needs and Strengths Assessment), as a targeted outcome for outcome improvement goal because it measures patient benefits targeted through services offered in the outpatient setting proposed in this project. The ANSA addresses a patient’s ability to function, providing evidence of the functional improvements expected to be seen by outpatient treatment. It is hypothesized that patients will be better served by providing ongoing outpatient treatment, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. Specifically, we believe that improved patient outcomes that include symptom reduction and improved functional status, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric and other inpatient facilities. If patients’ outcomes are not improved, it is more likely patients will disengage from services and may continue to over-utilize emergency services and inpatient care rather than engaging in preventive care. Since this patient outcome is proposed in conjunction with patient satisfaction as “stand-alone” measures, it will be valued at 50% of the Category 3 allocation for this proposed program.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1: P-1</strong>: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 6: P-1</strong>: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 11: IT-10.1</strong> Percent improvement over baseline of patient functional status scores</td>
<td><strong>Milestone 12: IT-10.1</strong> Percent improvement over baseline of patient functional status scores</td>
</tr>
<tr>
<td><strong>Goal</strong>: To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way</td>
<td><strong>Data Source</strong>: Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source</strong>: ANSA</td>
<td><strong>Data Source</strong>: ANSA</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment</strong>: $22,850.69</td>
<td><strong>Estimated Incentive Payment</strong>: $53,031.39</td>
<td><strong>Estimated Incentive Payment</strong>: $283,348.56</td>
<td><strong>Estimated Incentive Payment</strong>: $615,975.14</td>
</tr>
</tbody>
</table>

**Milestone 2: P-2**: Establish baseline

**Data Source**: literature review

**Goal**: determine how baseline will be established for patient satisfaction domain

**Estimated Incentive Payment**: $22,850.69

**Milestone 7: P-2**: Establish baseline

**Data Source**: Clinical records; monthly management reports

**Goal**: obtain baseline of satisfaction survey from patients receiving service

**Estimated Incentive Payment**: $53,031.39
<table>
<thead>
<tr>
<th></th>
<th>Outcome Measure: <strong>Functional Status</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RHP Performing Provider:</strong> Mental Health and Mental Retardation Authority of Harris County</td>
<td>TPI: 113180703</td>
</tr>
<tr>
<td>Related Category 1 or 2:</td>
<td>1.12.2</td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>Baseline will be collected from the 400 expected patients to be served in DY3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 3: P-3:** Develop and test data systems  
**Data Source:** Project record—summary of reviews  
**Goal:** Identify/modify one instrument to test in Yr. 3

**Milestone 8: P-3:** Develop and test data systems  
**Data Source:** Project record—summary of reviews, completed surveys  
**Goal:** Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3

**Estimated Incentive Payment:** $22,850.69  
**Estimated Incentive Payment:** $53,031.39

**Milestone 4: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Data Source:** Project reports, QI reports  
**Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations

**Milestone 9: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Data Source:** Project reports, QI reports  
**Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations

**Estimated Incentive Payment:** $22,850.69  
**Estimated Incentive Payment:** $53,031.39
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 5: P-5</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Milestone 10: P-5</strong>: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Goal</strong>: To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td><strong>Goal</strong>: To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
</tr>
<tr>
<td><strong>Data Source</strong>: minutes from stakeholder meetings</td>
<td><strong>Data Source</strong>: management team minutes, RHP collaborations</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal</strong>: To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td><strong>Goal</strong>: To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment</strong>: $22,850.69</td>
<td><strong>Estimated Incentive Payment</strong>: $53,031.39</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount</strong>: $114,253.45</td>
<td><strong>Year 3 Estimated Outcome Amount</strong>: $265,156.95</td>
<td><strong>Year 4 Estimated Outcome Amount</strong>: $283,348.56</td>
<td><strong>Year 5 Estimated Outcome Amount</strong>: $615,975.14</td>
</tr>
<tr>
<td>*TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: <strong>$1,278,734.11</strong></td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): IT-10.1: Functional Status

Unique RHP outcome identification numbers: 113180703.3.31

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Outcome Measure Description: IT-10.1: Demonstrate improvement in functional status
- Numerator: Percent improvement in functional status
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 5% over baseline scores.
- DY 5:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 10% over baseline scores.

Rationale:

The Adult Needs and Strengths Assessment (ANSA) is a multi-purpose tool developed to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. It has demonstrated reliability and validity. We propose to use the ANSA to measure aspects of functional status that are expected to improve as a result of the expansion of outpatient mental health services. Specifically, the ANSA measures Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Family/Caregiver Strengths and Needs, Strengths, Culture,
Psychiatric Hospitalizations, Crisis History. Furthermore the ANSA has shown sensitivity to change in public mental health settings such as the proposed program.

From an initial baseline to be conducted in DY 3, the goals for improvement in ANSA scores have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined, another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient outcomes. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified improved functional skills as measured by the ANSA (Adult Needs and Strengths Assessment), as a targeted outcome for outcome improvement goal because it measures patient benefits targeted through services offered in the outpatient setting proposed in this project. The ANSA-addresses a patient’s ability to function, providing evidence of the functional improvements expected to be seen by outpatient treatment. It is hypothesized that patients will be better served by providing ongoing outpatient treatment, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. Specifically, we believe that improved patient outcomes that include symptom reduction and improved functional status, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric and other inpatient facilities. If patients’ outcomes are not improved, it is more likely patients will disengage from services and may continue to over-utilize emergency services and inpatient care rather than engaging in preventive care. Since this patient outcome is proposed in conjunction with patient satisfaction as “stand-alone” measures, it will be valued at 50% of the Category 3 allocation for this proposed program.
**Outcome Measure:** Functional Status

**RHP Performing Provider:** Mental Health and Mental Retardation Authority of Harris County

**TPI:** 113180703

**Baseline will be taken from the 300 patients expected in DY3.**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1:</strong> P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 6:</strong> P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 11:</strong> IT-10.1 Percent improvement over baseline of patient functional status scores</td>
<td><strong>Milestone 12:</strong> IT-10.1 Percent improvement over baseline of patient functional status scores</td>
</tr>
<tr>
<td>Data Source: Meetings minutes, project flow charts and timelines</td>
<td>Data Source: Meetings minutes, project flow charts and timelines</td>
<td>Data Source: ANSA</td>
<td>Data Source: ANSA</td>
</tr>
<tr>
<td>Goal: To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way</td>
<td>Goal: To complete project planning process and implement</td>
<td>Goal: 5% increase over baseline in at least one domain of the ANSA</td>
<td>Goal: 10% increase in baseline in at least one domain of the ANSA</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $21,987.21</td>
<td><strong>Estimated Incentive Payment:</strong> $51,027.44</td>
<td><strong>Estimated Incentive Payment:</strong> $272,641.38</td>
<td><strong>Estimated Incentive Payment:</strong> $592,698.66</td>
</tr>
</tbody>
</table>

**Milestone 2:** P-2: Establish baseline

**Data Source:** literature review

**Goal:** determine how baseline will be established for patient satisfaction domain

**Estimated Incentive Payment:** $21,987.21

**Milestone 3:** P-3: Develop and test data systems

**Data Source:** Project record—summary of reviews

**Goal:** Identify/modify one instrument to test in Yr. 3

**Estimated Incentive Payment:** $21,987.21

**Milestone 4:** P-4: Establish baseline

**Data Source:** Clinical records; monthly management reports

**Goal:** obtain baseline of satisfaction survey from patients receiving service

**Estimated Incentive Payment:** $51,027.44

**Milestone 5:** P-5: Develop and test data systems

**Data Source:** Project record—summary of reviews, completed surveys

**Goal:** Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3

**Estimated Incentive Payment:** $51,027.44

**Estimated Incentive Payment:** $21,987.21

**Estimated Incentive Payment:** $51,027.44
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Milestone 4: P-4**: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Data Source**: Project reports, QI reports  
**Goal**: To improve processes and outcomes by implementing data-driven course corrections and innovations | **Milestone 9: P-4**: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Data Source**: Project reports, QI reports  
**Goal**: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations |  |  |
| **Estimated Incentive Payment**: $21,987.21 | **Estimated Incentive Payment**: $51,027.44 |  |  |
| **Milestone 5**: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders  
**Data Source**: minutes from stakeholder meetings  
**Goal**: To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers | **Milestone 10**: P-5: Disseminate findings, including lessons learned and best practices, to stakeholders  
**Data Source**: management team minutes, RHP collaborations  
**Goal**: To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers |  |  |
| **Estimated Incentive Payment**: $21,987.21 | **Estimated Incentive Payment**: $51,027.44 |  |  |
| **Year 2 Estimated Outcome Amount**: $109,936.04 | **Year 3 Estimated Outcome Amount**: $255,137.20 | **Year 4 Estimated Outcome Amount**: $272,641.38 | **Year 5 Estimated Outcome Amount**: $592,698.66 |

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,230,413.28
Title of Outcome Measure (Improvement Target): IT-10.1: Functional Status

Unique RHP outcome identification numbers: 113180703.3.32

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Outcome Measure Description: IT-10.1: Demonstrate improvement in functional status
- Numerator: Percent improvement in functional status
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 5% over baseline scores.
- DY 5:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 10% over baseline scores.

Rationale:

The Adult Needs and Strengths Assessment (ANSA) is a multi-purpose tool developed to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. It has demonstrated reliability and validity. We propose to use the ANSA to measure aspects of functional status that are anticipated to show improvement through the expansion of outpatient mental health services. Specifically, the ANSA measures Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Family/Caregiver Strengths and Needs, Strengths, Culture, Psychiatric Hospitalizations, Crisis History. Furthermore the ANSA has shown
sensitivity to change in public mental health settings such as the proposed program.

From an initial baseline to be conducted in DY 3, the goals for improvement in ANSA scores have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined, another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient outcomes. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified improved functional skills as measured by the ANSA (Adult Needs and Strengths Assessment), as a targeted outcome for outcome improvement goal because it measures patient benefits targeted through services offered in the outpatient setting proposed in this project. The ANSA-addresses a patient’s ability to function, providing evidence of the functional improvements expected to be seen by outpatient treatment. It is hypothesized that patients will be better served by providing ongoing outpatient treatment, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. Specifically, we believe that improved patient outcomes that include symptom reduction and improved functional status, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric and other inpatient facilities. If patients’ outcomes are not improved, it is more likely patients will disengage from services and may continue to over-utilize emergency services and inpatient care rather than engaging in preventive care. Since this patient outcome is proposed in conjunction with patient satisfaction as “stand-alone” measures, it will be valued at 50% of the Category 3 allocation for this proposed program.
<table>
<thead>
<tr>
<th>Milestone 1: P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Milestone 6: P-1: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Milestone 11: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
<th>Milestone 12: IT-10.1 Percent improvement over baseline of patient functional status scores</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source:</strong> ANSA</td>
<td><strong>Data Source:</strong> ANSA</td>
</tr>
<tr>
<td><strong>Goal:</strong> To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way</td>
<td><strong>Goal:</strong> To complete project planning process and implement</td>
<td><strong>Goal:</strong> 5% increase over baseline in at least one domain of the ANSA</td>
<td><strong>Goal:</strong> 10% increase in baseline in at least one domain of the ANSA</td>
</tr>
<tr>
<td>Estimated Incentive Payment: $2,640.99</td>
<td>Estimated Incentive Payment: $6,129.16</td>
<td>Estimated Incentive Payment: $32,748.30</td>
<td>Estimated Incentive Payment: $71,191.97</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 2: P-2: Establish baseline</th>
<th>Milestone 7: P-2: Establish baseline</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong> literature review</td>
<td><strong>Data Source:</strong> Clinical records; monthly management reports</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Goal:</strong> determine how baseline will be established for patient satisfaction domain</td>
<td><strong>Goal:</strong> obtain baseline of satisfaction survey from patients receiving service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Incentive Payment: $2,640.99</td>
<td>Estimated Incentive Payment: $6,129.16</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
</tbody>
</table>

**Milestone 3: P-3:** Develop and test data systems  
**Data Source:** Project record—summary of reviews  
**Goal:** Identify/modify one instrument to test in Yr. 3

**Milestone 8: P-3:** Develop and test data systems  
**Data Source:** Project record—summary of reviews, completed surveys  
**Goal:** Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3

**Estimated Incentive Payment:** $2,640.99

**Milestone 4: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Data Source:** Project reports, QI reports  
**Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations

**Milestone 9: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Data Source:** Project reports, QI reports  
**Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations

**Estimated Incentive Payment:** $2,640.99

**Region 3**

**Regional Healthcare Partnership Plan**
<table>
<thead>
<tr>
<th>Outcome Measure: <strong>Functional Status</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RHP Performing Provider:</strong> Mental Health and Mental Retardation Authority of Harris County</td>
</tr>
<tr>
<td><strong>TPI:</strong> 113180703</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Related Category 1 or 2:</strong> 1.12.2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong> Baseline to be measured in DY 3 with an anticipated 1500 patients served</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</th>
<th><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</th>
<th><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</th>
<th><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 5:</strong> P-5 Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Milestone 10:</strong> P-5: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> minutes from stakeholder meetings</td>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $2,640.99</td>
<td><strong>Estimated Incentive Payment:</strong> $6,129.16</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $13,204.96</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $30,645.79</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $32,748.30</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $71,191.97</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $147,791.02
Title of Outcome Measure (Improvement Target): IT-10.1: Functional Status

Unique RHP outcome identification numbers: 113180703.3.33

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

Outcome Measure Description: IT-10.1: Demonstrate improvement in functional status

- Numerator: Percent improvement in functional status
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 5% over baseline scores.

- DY 5:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 10% over baseline scores.

Rationale:

The Adult Needs and Strengths Assessment (ANSA) is a multi-purpose tool developed to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. It has demonstrated reliability and validity. We propose to use the ANSA to measure aspects of functional status that are expected to improve as a result of the expansion of outpatient mental health services. Specifically, the ANSA measures Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Family/Caregiver Strengths and Needs, Strengths, Culture, Psychiatric Hospitalizations, Crisis History. Furthermore the ANSA has shown sensitivity to
change in public mental health settings such as the proposed program.

From an initial baseline to be conducted in DY 3, the goals for improvement in ANSA scores have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined, another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient outcomes. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified improved functional skills as measured by the ANSA (Adult Needs and Strengths Assessment), as a targeted outcome for outcome improvement goal because it measures patient benefits targeted through services offered in the outpatient setting proposed in this project. The ANSA-addresses a patient’s ability to function, providing evidence of the functional improvements expected to be seen by outpatient treatment. It is hypothesized that patients will be better served by providing ongoing outpatient treatment, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. Specifically, we believe that improved patient outcomes that include symptom reduction and improved functional status, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric and other inpatient facilities. If patients’ outcomes are not improved, it is more likely patients will disengage from services and may continue to over-utilize emergency services and inpatient care rather than engaging in preventive care. Since this patient outcome is proposed in conjunction with patient satisfaction as “stand-alone” measures, it will be valued at 50% of the Category 3 allocation for this proposed program.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1: P-1:</strong> Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 6: P-1:</strong> Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 11:</strong> IT-10.1 Percent improvement over baseline of patient functional status scores</td>
<td><strong>Milestone 12:</strong> IT-10.1 Percent improvement over baseline of patient functional status scores</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source:</strong> ANSA</td>
<td><strong>Data Source:</strong> ANSA</td>
</tr>
<tr>
<td><strong>Goal:</strong> To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way</td>
<td><strong>Goal:</strong> To complete project planning process and implement</td>
<td><strong>Goal:</strong> 5% increase over baseline in at least one domain of the ANSA</td>
<td><strong>Goal:</strong> 10% increase in baseline in at least one domain of the ANSA</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $1,408.52</td>
<td><strong>Estimated Incentive Payment:</strong> $3,268.86</td>
<td><strong>Estimated Incentive Payment:</strong> $17,465.66</td>
<td><strong>Estimated Incentive Payment:</strong> $37,968.82</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 2: P-2:</strong> Establish baseline</td>
<td><strong>Milestone 7: P-2:</strong> Establish baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> literature review</td>
<td><strong>Data Source:</strong> Clinical records; monthly management reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> determine how baseline will be established for patient satisfaction domain</td>
<td><strong>Goal:</strong> obtain baseline of satisfaction survey from patients receiving service</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $1,408.52</td>
<td><strong>Estimated Incentive Payment:</strong> $3,268.86</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>Milestone 3 : P-3:</strong> Develop and test data systems  &lt;br&gt; <strong>Data Source:</strong> Project record—summary of reviews  &lt;br&gt; <strong>Goal:</strong> Identify/modify one instrument to test in Yr. 3</td>
<td><strong>Milestone 8: P-3:</strong> Develop and test data systems  &lt;br&gt; <strong>Data Source:</strong> Project record—summary of reviews, completed surveys  &lt;br&gt; <strong>Goal:</strong> Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $1,408.52</td>
<td><strong>Estimated Incentive Payment:</strong> $3,268.86</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>(10/1/2014 – 9/30/2015)</td>
<td>(10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Milestone 4: P-4:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  &lt;br&gt; <strong>Data Source:</strong> Project reports, QI reports  &lt;br&gt; <strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Milestone 9: P-4:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  &lt;br&gt; <strong>Data Source:</strong> Project reports, QI reports  &lt;br&gt; <strong>Goal:</strong> To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations</td>
</tr>
<tr>
<td></td>
<td><strong>Estimated Incentive Payment:</strong> $1,408.52</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td><strong>Milestone 5: P-5</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Milestone 10: P-5:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
</tr>
<tr>
<td><strong>Data Source:</strong> minutes from stakeholder meetings</td>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
</tr>
<tr>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $1,408.52</td>
<td><strong>Estimated Incentive Payment:</strong> $3,268.86</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $7,042.60</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $16,344.32</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $78,821.41</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:</strong> $78,821.41</td>
</tr>
</tbody>
</table>
**Title of Outcome Measure (Improvement Target):** IT-10.1: Functional Status

**Unique RHP outcome identification numbers:** 113180703.3.34

**Performing Provider/TPI:** Mental Health and Mental Retardation Authority of Harris County/113180703

**Outcome Measure Description:** IT-10.1: Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.

b. Data source: Provider may select a validated assessment tool for quality of life.

- Numerator: Percent improvement in functional status
- Denominator: Number of patients who were administered the survey

**Process Milestones:**

- **DY 2:**
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

- **DY 3:**
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

**Outcome Improvement Targets for each year:**

- **DY 4:**
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 5 % over baseline scores.

- **DY 5:**
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 10 % over baseline scores.

**Rationale:**

The Adult Needs and Strengths Assessment (ANSA) is a multi-purpose tool developed to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. It has demonstrated reliability and validity. We propose to use the ANSA to measure aspects of functional status that are anticipated to show improvement through the expansion of outpatient mental health services. Specifically, the ANSA measures Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Family/Caregiver Strengths and Needs, Strengths,
Culture, Psychiatric Hospitalizations, Crisis History. Furthermore the ANSA has shown 
sensitivity to change in public mental health settings such as the proposed program.

From an initial baseline to be conducted in DY 3, the goals for improvement in ANSA 
scores have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 
have been determined, another cycle of Plan Do Study Act (PDSA) can also be executed to 
determine the successes and the need for improvements in addressing patient outcomes. This 
information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to 
transforming the current health care delivery system toward a patient-centered, coordinated 
delivery model that improves patient satisfaction and health outcomes. Based on these 
objectives, the proposed program has identified improved functional skills as measured by the 
ANSA (Adult Needs and Strengths Assessment), as a targeted outcome for outcome 
improvement goal because it measures patient benefits targeted through services offered in the 
outpatient setting proposed in this project. The ANSA-addresses a patient’s ability to function, 
providing evidence of the functional improvements expected to be seen by outpatient treatment. 
It is hypothesized that patients will be better served by providing ongoing outpatient treatment, 
i.e. when the menu of service options is not sharply curtailed by agency resource limitations. 
Specifically, we believe that improved patient outcomes that include symptom reduction and 
improved functional status, access to providers, and communication with providers, will reduce 
preventable admissions and readmissions to psychiatric and other inpatient facilities. If patients’ 
outcomes are not improved, it is more likely patients will disengage from services and may 
continue to over-utilize emergency services and inpatient care rather than engaging in preventive 
care. Since this patient outcome is proposed in conjunction with patient satisfaction as “stand-
only” measures, it will be valued at 50% of the Category 3 allocation for this proposed program.
<table>
<thead>
<tr>
<th>Milestone 1: P-1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Milestone 6: P-1</td>
<td>Milestone 11: IT-10.1 Percent improvement over baseline of patient functional status scores</td>
<td>Milestone 12: IT-10.1 Percent improvement over baseline of patient functional status scores</td>
<td>Milestone 12: IT-10.1 Percent improvement over baseline of patient functional status scores</td>
</tr>
<tr>
<td>Data Source: Meetings minutes, project flow charts and timelines</td>
<td>Data Source: Meetings minutes, project flow charts and timelines</td>
<td>Data Source: ANSA</td>
<td>Data Source: ANSA</td>
<td>Data Source: ANSA</td>
</tr>
<tr>
<td>Goal: To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way</td>
<td>Goal: To complete project planning process and implement</td>
<td>Goal: 5% increase over baseline</td>
<td>Goal: 10% increase in baseline</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$23,753.72</td>
<td>$55,127.11</td>
<td>$176,727.65</td>
<td>$384,190.54</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 2: P-2</th>
<th>Milestone 7: P-2</th>
<th>Milestone 12: P-1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish baseline</td>
<td>Establish baseline</td>
<td>Establish baseline</td>
</tr>
<tr>
<td>Data Source: literature review</td>
<td>Data Source: Clinical records; monthly management reports</td>
<td>Data Source: ANSA</td>
</tr>
<tr>
<td>Goal: determine how baseline will be established for patient satisfaction domain</td>
<td>Goal: obtain baseline of functional status from patients receiving service</td>
<td>Goal: 10% increase in baseline</td>
</tr>
<tr>
<td>RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td>
<td>TPI: 113180703</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2: 1.12.2</td>
<td>113180703.2.5</td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be collected from new patients in DY3, anticipated to be about 200</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 3: P-3:</strong> Develop and test data systems</td>
<td>Milestone 8: P-3: Develop and test data systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project record—summary of reviews</td>
<td><strong>Data Source:</strong> Project record—summary of reviews, completed surveys</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> Identify/modify one instrument to test in Yr. 3</td>
<td><strong>Goal:</strong> Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Incentive Payment: $23,753.72</td>
<td>Estimated Incentive Payment: $55,127.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $71,261.15</td>
<td>Year 3 Estimated Outcome Amount: $165,381.34</td>
<td>Year 4 Estimated Outcome Amount: $176,727.65</td>
<td>Year 5 Estimated Outcome Amount: $384,190.54</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $797,560.68
Title of Outcome Measure (Improvement Target): IT-10.1: Functional Status

Unique RHP outcome identification numbers: 113180703.3.35

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Outcome Measure Description: IT-10.1: Demonstrate improvement in functional status
- Numerator: Percent improvement in functional status
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 5% over baseline scores.
- DY 5:
  - IT 10.1: Rate 1: Improve patient functional status as measured the ANSA by 10% over baseline scores.

Rationale:

The Adult Needs and Strengths Assessment (ANSA) is a multi-purpose tool developed to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. It has demonstrated reliability and validity. We propose to use the ANSA to measure aspects of functional status that are expected to improve as a result of the expansion of outpatient mental health services. Specifically, the ANSA measures Risk Behaviors, Behavioral Health Needs, Life Domain Functioning, Family/Caregiver Strengths and Needs, Strengths, Culture, Psychiatric Hospitalizations, Crisis History. Furthermore the ANSA has shown sensitivity to
change in public mental health settings such as the proposed program.

From an initial baseline to be conducted in DY 3, the goals for improvement in ANSA scores have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined, another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient outcomes. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified improved functional skills as measured by the ANSA (Adult Needs and Strengths Assessment), as a targeted outcome for outcome improvement goal because it measures patient benefits targeted through services offered in the outpatient setting proposed in this project. The ANSA-addresses a patient’s ability to function, providing evidence of the functional improvements expected to be seen by outpatient treatment. It is hypothesized that patients will be better served by providing ongoing outpatient treatment, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. Specifically, we believe that improved patient outcomes that include symptom reduction and improved functional status, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric and other inpatient facilities. If patients’ outcomes are not improved, it is more likely patients will disengage from services and may continue to over-utilize emergency services and inpatient care rather than engaging in preventive care. Since this patient outcome is proposed in conjunction with patient satisfaction as “stand-alone” measures, it will be valued at 50% of the Category 3 allocation for this proposed program.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1: P-1:</strong> Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 6: P-1:</strong> Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 11:</strong> IT-10.1 Percent improvement over baseline of patient functional status scores</td>
<td><strong>Milestone 12:</strong> IT-10.1 Percent improvement over baseline of patient functional status scores</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source:</strong> ANSA</td>
<td><strong>Data Source:</strong> ANSA</td>
</tr>
<tr>
<td><strong>Goal:</strong> To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way</td>
<td><strong>Goal:</strong> To complete project planning process and implement</td>
<td><strong>Goal:</strong> 5% increase over baseline in at least one domain of the ANSA</td>
<td><strong>Goal:</strong> 10% increase in baseline in at least one domain of the ANSA</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $16,978.17</td>
<td><strong>Estimated Incentive Payment:</strong> $39,402.57</td>
<td><strong>Estimated Incentive Payment:</strong> N/A</td>
<td><strong>Estimated Incentive Payment:</strong> N/A</td>
</tr>
</tbody>
</table>

**Milestone 2: P-2:** Establish baseline

**Data Source:** literature review

**Goal:** determine how baseline will be established for patient satisfaction domain

**Estimated Incentive Payment:** $16,978.17

**Milestone 7: P-2:** Establish baseline

**Data Source:** Clinical records; monthly management reports

**Goal:** obtain baseline of satisfaction survey from patients receiving service

**Estimated Incentive Payment:** $39,402.57

**Milestone 3: P-3:** Develop and test data systems

**Data Source:** Project record—summary of reviews

**Goal:** Identify/modify one instrument to test in Yr. 3

**Estimated Incentive Payment:** $16,978.17

**Milestone 8: P-3:** Develop and test data systems

**Data Source:** Project record—summary of reviews, completed surveys

**Goal:** Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3

**Estimated Incentive Payment:** N/A

**Estimated Incentive Payment:** N/A
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 4: P-4:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td><strong>Milestone 9: P-4:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project reports, QI reports</td>
<td><strong>Data Source:</strong> Project reports, QI reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $16,978.17</td>
<td><strong>Estimated Incentive Payment:</strong> $39,402.57</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone 5: P-5</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Milestone 10: P-5:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> minutes from stakeholder meetings</td>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $16,978.17</td>
<td><strong>Estimated Incentive Payment:</strong> $39,402.57</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $84,890.84</td>
<td>Year 3 Estimated Outcome Amount: $197,012.84</td>
<td>Year 4 Estimated Outcome Amount: $210,529.29</td>
<td>Year 5 Estimated Outcome Amount: $457,105.33</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $950,105.33</td>
<td></td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.36

Outcome Measure Description:
IT-6.1: Percent improvement over baseline of patient satisfaction scores
- Numerator: Percent improvement in CSQ8 scores
- Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5% over baseline scores for CSQ8 measure of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10% over baseline scores for CSQ8 measure of patient satisfaction

Rationale:
The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. This initiative will permit MHMRA, the performing provider, to improve on previous efforts to measure patient experience, through selection of reliable, valid measures with external...
benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain as measured by the CSQ-8.

The goals for improvement have been set at obtaining an average score of 2.5 in DY4 and then increase by 25% over DY 4 in the final DY. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient experience is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Patients entering services will be given the CSQ-8 upon completion.

**Outcome Measure Valuation:**
Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe that if patients are satisfied with services received and communication with providers, they would be more willing to continue in ongoing services, thereby reducing preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
| Milestone 1: P-1: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans | Metric 1: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information | Data Source: Meetings minutes, project flow charts and timelines | Goal: To integrate stakeholder input in development of program plan |
| --- | --- | --- | |
| Milestone 6: P-1: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans | Metric 1: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information | Data Source: Meetings minutes, project flow charts and timelines | Goal: To complete project planning process and implement |
| Milestone 11: OD-6: Patient Satisfaction | Metric 1: IT 6-1 Percent improvement over baseline of patient satisfaction scores |
| a. Numerator: Total average score of the CSQ8 measure of patient satisfaction |
| b. Denominator: Number of patients who were administered the survey |
| Data Source: CSQ8 | Goal: obtain an average score of 2.5 or higher |
| Milestone 12: OD-6: Patient Satisfaction | Metric 1: IT 6-1 Percent improvement over baseline of patient satisfaction scores |
| a. Numerator: Total average score of the CSQ8 measure of patient satisfaction |
| b. Denominator: Number of patients who were administered the survey |
| Data Source: CSQ8 | Goal: increase 25% over DY4 |

| Estimated Incentive Payment: $8,613.21 | Estimated Incentive Payment: $19,989.36 | Estimated Incentive Payment: $106,803.87 | Estimated Incentive Payment: $232,182.32 |

<p>| Milestone 2: P-2: Establish baseline | Metric 1: Identify domains of patient satisfaction to be measured | Data Source: literature review | Goal: determine how baseline will be established for patient satisfaction domain |
| Milestone 7: P-2: Establish baseline | Metric 1: Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction | Data Source: Clinical records; monthly management reports | Goal: obtain baseline of satisfaction survey from patients receiving service |
| Estimated Incentive Payment: $8,613.21 | Estimated Incentive Payment: $19,989.36 | Estimated Incentive Payment: $232,182.32 |</p>
<table>
<thead>
<tr>
<th>Milestone 3: P-3:</th>
<th>Milestone 8: P-3:</th>
<th>Estimated Incentive Payment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop and test data systems</td>
<td>Develop and test data systems</td>
<td>$8,613.21</td>
</tr>
<tr>
<td>Metric 1: Review satisfaction measures for use with the target population and their clinical teams</td>
<td>Metric 1: Review satisfaction measures for use with the target population</td>
<td></td>
</tr>
<tr>
<td>Data Source: Project record—summary of reviews</td>
<td>Data Source: Project record—summary of reviews, completed surveys</td>
<td></td>
</tr>
<tr>
<td>Goal: Identify/modify one instrument to test in Yr. 3</td>
<td>Goal: Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3</td>
<td></td>
</tr>
<tr>
<td>Milestone 4: P-4:</td>
<td>Milestone 9: P-9:</td>
<td>Estimated Incentive Payment:</td>
</tr>
<tr>
<td>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>$19,989.36</td>
</tr>
<tr>
<td>Metric 4: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td>Metric 9: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td></td>
</tr>
<tr>
<td>Data Source: Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td>Data Source: Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td></td>
</tr>
<tr>
<td>Goal: To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td>Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2:</td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>MHMRA of Harris County</td>
<td>113180703</td>
<td></td>
</tr>
</tbody>
</table>

| Starting Point/Baseline: | Baseline will be collected in DY3 with an anticipated 40 patients per new team |

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Incentive Payment:</td>
<td>$8,613.21</td>
<td>Estimated Incentive Payment:</td>
<td>$19,989.36</td>
</tr>
<tr>
<td><strong>Milestone 5: P-5</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Metric 5: Report status, progress and lessons learned to stakeholders</strong></td>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders</td>
</tr>
<tr>
<td><strong>Metric 10: P-5:</strong> Disseminate findings to stakeholders</td>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders</td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount:</th>
<th>Year 3 Estimated Outcome Amount:</th>
<th>Year 4 Estimated Outcome Amount:</th>
<th>Year 5 Estimated Outcome Amount:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$43,066.07</td>
<td>$99,946.82</td>
<td>$106,803.87</td>
<td>$232,182.32</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $481,990.08
Mental Health and Mental Retardation Authority of Harris County
Pass 2
Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Unique RHP outcome identification numbers: 113180703.3.15

Outcome Measure Description:
- IT-6.1: Percent improvement over baseline of patient satisfaction scores
  - Numerator: Percent improvement in targeted patient satisfaction domain
  - Denominator: Number of patients who were administered the survey

Process Milestones:
- DY 2:
  - P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5% over baseline scores for the communication with provider domain as measured by the CAPHAS survey
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10% over baseline scores for the communication with provider domain as measured by the CAPHAS survey

Rationale:
The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the
particular program population, we will be more accurate in our assessment of the target outcome. This initiative will permit MHMRA, the performing provider, to improve on previous efforts to measure patient experience, through selection of reliable, valid measures with external benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain of “How Well their Doctors Communicate” by DY2.

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient experience is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Both the Adult Visit Survey and the Adult Twelve Month Survey versions of the CAHPS questionnaire will be employed. Every new patient referred for outpatient services will receive the Adult Visit Survey after the completion of their first outpatient visit then the Adult Twelve Month Survey version will be used yearly for ongoing patients.

**Outcome Measure Valuation:**
Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>MHMRA of Harris County</th>
<th>IT-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2:</td>
<td>113180703</td>
<td>113180703.3.15</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>113180703.1.8</td>
<td>Baseline will be established in DY3 with the 1100 patients anticipated to be served</td>
</tr>
</tbody>
</table>

| Year 2 | Year 3 | Year 4 | Year 5 |
| Milestone 1: P-1: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans | Milestone 6: P-1: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans | Milestone 11: OD-6: Patient Satisfaction | Milestone 12: OD-6: Patient Satisfaction |
| Metric 1: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information | Metric 6: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information | Metric 11: IT 6-1 Percent improvement over baseline of patient satisfaction scores | Metric 12: IT 6-1 Percent improvement over baseline of patient satisfaction scores |
| Data Source: Meetings minutes, project flow charts and timelines | Data Source: Meetings minutes, project flow charts and timelines | a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPH domain | a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPH domain |
| Goal: To integrate stakeholder input in the development of program plan | Goal: To complete project planning process and implement | b. Denominator: Number of patients who were administered the survey | b. Denominator: Number of patients who were administered the survey |
| Estimated Incentive Payment | Estimated Incentive Payment | Data Source: Patient survey | Data Source: Patient survey |
| $14,671.50 | $34,761.53 | Goal: 5% increase over baseline | Goal: 10% increase over baseline |

| Estimated Incentive Payment | $188,084.26 | $407,431.37 |

Regional Healthcare Partnership Plan  Region 3
<table>
<thead>
<tr>
<th>Milestone 2: P-2:</th>
<th>Establish baseline</th>
<th>Metric 2: Identify domains of patient satisfaction to be measured</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong></td>
<td>literature review</td>
<td><strong>Goal:</strong> determine how baseline will be established for patient satisfaction domain</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 7: P-2:</th>
<th>Establish baseline</th>
<th>Metric 7: Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source:</strong></td>
<td>Clinical records; monthly management reports</td>
<td><strong>Goal:</strong> obtain baseline of satisfaction survey from patients receiving service</td>
</tr>
</tbody>
</table>

**Starting Point/Baseline:** Baseline will be established in DY3 with the 1100 patients anticipated to be served

**Estimated Incentive Payment:**
- Year 2: $14,671.50
- Year 3: $34,761.53

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**MHMRA of Harris County**
113180703

**Related Category 1 or 2:**
113180703.1.8

**Percent improvement over baseline of patient satisfaction scores**
<table>
<thead>
<tr>
<th>Milestone 3: P-3:</th>
<th>Milestone 8: P-3:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop and test data systems</td>
<td>Develop and test data systems</td>
</tr>
<tr>
<td>Metric 3: Review satisfaction measures for use with the target population and their clinical teams</td>
<td>Metric 8: Review and revise satisfaction measures for use with the target population</td>
</tr>
<tr>
<td>Data Source: Project record—summary of reviews</td>
<td>Data Source: Project record—summary of reviews, completed surveys</td>
</tr>
<tr>
<td>Goal: Identify/modify one instrument to test in Yr. 3</td>
<td>Goal: Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3</td>
</tr>
</tbody>
</table>

<p>| Estimated Incentive Payment: $14,671.50 | Estimated Incentive Payment: $34,761.53 |</p>
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 4: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Metric 4:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles  
**Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement  
**Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations  

**Milestone 9: P-9:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  
**Metric 9:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles  
**Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement  
**Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations  

**Estimated Incentive Payment:**  
- Year 2: $14,671.50  
- Year 3: $34,761.53
<table>
<thead>
<tr>
<th>Milestone 5: P-5</th>
<th>Milestone 10: P-5</th>
<th>Estimated Incentive Payment:</th>
<th>Year 2 Estimated Outcome Amount:</th>
<th>Year 3 Estimated Outcome Amount:</th>
<th>Year 4 Estimated Outcome Amount:</th>
<th>Year 5 Estimated Outcome Amount:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>Disseminate findings to stakeholders</td>
<td>$14,671.50</td>
<td>$73,357.51</td>
<td>$173,807.64</td>
<td>$188,084.26</td>
<td>$407,431.37</td>
</tr>
<tr>
<td>Metric 5: Report status, progress and lessons learned to stakeholders</td>
<td>Metric 10: Report status, progress and lessons learned to stakeholders</td>
<td>$34,761.53</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: management team minutes, RHP collaborations</td>
<td>Data Source: management team minutes, RHP collaborations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: To disseminate information about the project and solicit input from stakeholders</td>
<td>Goal: To disseminate information about the project and solicit input from stakeholders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $842,680.77**
**Title of Outcome Measure (Improvement Target):** IT-6.1: Percent improvement over baseline of patient satisfaction scores

**Performing Provider / TPI:** Mental Health and Mental Retardation Authority of Harris County / 113180703

**Unique RHP outcome identification numbers:** 113180703.3.16

**Outcome Measure Description:**
IT-6.1: Percent improvement over baseline of patient satisfaction scores
- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

**Process Milestones:**
- **DY 2:**
  - P-1- Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- **DY 3:**
  - P-1- Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

**Outcome Improvement Targets for each year:**
- **DY 4:**
  - IT 6.1: Rate 1: Improve patient satisfaction by 5% over baseline scores for the communication with provider domain as measured by the CAPHS survey
- **DY 5:**
  - IT 6.1: Rate 1: Improve patient satisfaction by 10% over baseline scores for the communication with provider domain as measured by the CAPHS survey

**Rationale:**
The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department
and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. This initiative will permit MHMRA, the performing provider, to improve on previous efforts to measure patient experience, through selection of reliable, valid measures with external benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain of “How Well their Doctors Communicate” by DY2.

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient experience is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Both the Adult Visit Survey and the Adult Twelve Month Survey versions of the CAHPS questionnaire will be employed. Every new patient referred for outpatient services will receive the Adult Visit Survey after the completion of their first outpatient visit then the Adult Twelve Month Survey version will be used yearly for ongoing patients.

**Outcome Measure Valuation:**
Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Project planning</td>
<td>Stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Project planning, engage stakeholders, identify current capacity, project staff, RHP partners and other key parties to gather relevant information</td>
<td>OD-6: Patient Satisfaction</td>
<td>Patient satisfaction</td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
</tr>
<tr>
<td>Metric 1:</td>
<td>Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td>Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td>Percent improvement in targeted patient satisfaction as measured by the CAPHS domain</td>
<td>% increase over baseline</td>
<td>10% increase over baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source:</td>
<td>Meetings minutes, project flow charts and timelines</td>
<td>Meetings minutes, project flow charts and timelines</td>
<td>Patient survey</td>
<td>Patient survey</td>
<td>Patient survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal:</td>
<td>To integrate stakeholder input in development of program plan</td>
<td>To complete project planning process and implement</td>
<td>5% increase over baseline</td>
<td>10% increase over baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$7,801.25</td>
<td>$18,483.69</td>
<td>$100,009.71</td>
<td>$216,642.77</td>
</tr>
<tr>
<td>113180703.3.16</td>
<td>IT-6.1</td>
<td>Percent improvement over baseline of patient satisfaction scores</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>-------</td>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>MHMRA of Harris County</td>
<td>113180703</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2:</td>
<td>113180703.2.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>Baseline to be taken in DY3 from the estimated 80 patients in program</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

Milestone 2: P-2: Establish baseline

**Metric 1:** Identify domains of patient satisfaction to be measured

**Data Source:** literature review

**Goal:** determine how baseline will be established for patient satisfaction domain

Milestone 7: P-2: Establish baseline

**Metric 1:** Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction

**Data Source:** Clinical records; monthly management reports

**Goal:** obtain baseline of satisfaction survey from patients receiving service in DY 3

**Estimated Incentive Payment:** $7,801.25

---

**Estimated Incentive Payment:** $18,483.69

N/A

N/A

---
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone 3: P-3: Develop and test data systems</td>
<td>Milestone 8: P-3: Develop and test data systems</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Metric 1</strong>: Review satisfaction measures for use with the target population and their clinical teams</td>
<td><strong>Metric 1</strong>: Review satisfaction measures for use with the target population</td>
<td><strong>Data Source</strong>: Project record—summary of reviews, completed surveys</td>
<td><strong>Goal</strong>: Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3</td>
</tr>
<tr>
<td><strong>Data Source</strong>: Project record—summary of reviews</td>
<td><strong>Goal</strong>: Identify/modify one instrument to test in Yr. 3</td>
<td><strong>Goal</strong>: Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3</td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment</strong>: $7,801.25</td>
<td><strong>Estimated Incentive Payment</strong>: $18,483.69</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Project 1:

**Project Title:** IT-6.1

**Project Description:** Percent improvement over baseline of patient satisfaction scores

<table>
<thead>
<tr>
<th>MHMRA of Harris County</th>
<th>113180703</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Related Category 1 or 2:</strong></td>
<td>113180703.2.8</td>
</tr>
</tbody>
</table>

**Starting Point/Baseline:** Baseline to be taken in DY3 from the estimated 80 patients in program

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 4: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles

**Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement

**Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations

**Estimated Incentive Payment:** $7,801.25

**Milestone 9: P-9:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles

**Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement

**Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations

**Estimated Incentive Payment:** $18,483.69
<table>
<thead>
<tr>
<th>Related Category 1 or 2:</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHMRA of Harris County</td>
<td>113180703</td>
</tr>
<tr>
<td>Related Category 1 or 2:</td>
<td>113180703.2.8</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline to be taken in DY3 from the estimated 80 patients in program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 5: P-5</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Milestone 10: P-5</strong> Disseminate findings to stakeholders</td>
<td>Metric 1: Report status, progress and lessons learned to stakeholders</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders</td>
</tr>
<tr>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td><strong>Data Source:</strong> management team minutes, RHP collaborations</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders</td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $7,801.25</td>
<td><strong>Estimated Incentive Payment:</strong> $18,483.69</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $</td>
</tr>
<tr>
<td>$39,006.26</td>
<td>$92,418.43</td>
<td>$100,009.71</td>
<td>$216,642.77</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $448,077.17
Title of Outcome Measure (Improvement Target): IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate

Performing Provider / TPI: Mental Health and Mental Retardation Authority of Harris County / 113180703

Unique RHP outcome identification number: 113180703.3.17

Outcome Measure Description:
IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate
- Numerator: The number of readmissions, for patients in the target population 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. If an index admission has more than 1 readmission, only the first is counted as a readmission.
- Denominator: The number of admissions, for patients in the target population 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of behavioral health and substance abuse and with a complete claims history for the 12 months prior to admission

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4: IT-3.8 5% decrease in re-admissions over baseline
- DY 5: IT-3.8 10% decrease in re-admissions over baseline

Rationale:
The goal of inpatient psychiatric/behavioral care is to stabilize an individual’s condition and facilitate successful reintegration into everyday life. For people with IDD/ASD and co-occurring mental illness, the supports to promote this goal must be coordinated by people who are knowledgeable in developmental disabilities, and often guided after discharge to help the person whose cognitive/intellectual abilities are often barriers to following through with aftercare. The lack of coordinated post-discharge plans and follow-through often result in re-hospitalizations or admission to very expensive and restrictive institutional care, which in Texas exceeds $177,624 per person, per year. The proposed model is intended to reduce the costs of healthcare by preventing these outcomes and demonstrating these benefits through the selected Category 3 measures.

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in establish baselines in DY 3 that will be used to evaluate the project’s outcomes in DY4 and DY5. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4).

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing outcomes. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:** Our local region has identified general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs), as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more successful linkage to post-discharge treatment and services that prevent readmissions. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are
dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1: P-1:</strong> Project planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 5: P-2:</strong> Establish Baselines</td>
<td><strong>IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate</strong></td>
<td><strong>IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate</strong></td>
</tr>
<tr>
<td><strong>Metric 1: P-1:</strong> Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td><strong>Metric 5: P-2:</strong> Percent of arrests per consumer pre/post psychosocial rehab intervention</td>
<td><strong>Goal:</strong> 5% decrease in admissions over baseline</td>
<td><strong>Goal:</strong> 10% decrease in admissions over baseline</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Meetings minutes and timelines</td>
<td>a. Numerator: The number of arrests per year per consumer after receiving psychosocial rehab intervention. b Denominator: The number of arrests per year per consumer before receiving psychosocial rehab intervention.</td>
<td><strong>a Numerator:</strong> The number of readmissions, for patients in the target population 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. If an index admission has more than 1 readmission, only the first is counted as a readmission. b Denominator: The number of admissions, for patients in the target population 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of behavioral health and substance abuse and with a complete claims history for the 12 months prior to admission</td>
<td><strong>a Numerator:</strong> The number of readmissions, for patients in the target population 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. If an index admission has more than 1 readmission, only the first is counted as a readmission. b Denominator: The number of admissions, for patients in the target population 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of behavioral health and substance abuse and with a complete claims history for the 12 months prior to admission</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,356.70</td>
<td>$24,538.37</td>
<td>$106,215.85</td>
<td>$230,086.60</td>
</tr>
<tr>
<td><strong>Milestone 2: P-3</strong></td>
<td><strong>Milestone 6: P-3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 2: P-3</strong></td>
<td><strong>Metric 6: P-3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop and test data systems</td>
<td>Develop and test data systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Meeting minutes</td>
<td>Data Source: Law enforcement partners, project records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: Establish method to track psychosocial rehab data across multiple organizations (e.g., MHMRA, St. Joseph’s House and police departments)</td>
<td>Goal: Test and revise data collection system in order to measure of baseline by end of Yr. 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong></td>
<td><strong>Estimated Incentive Payment:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10,356.70</td>
<td>$24,538.37</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Milestone 3: P-4</strong></th>
<th><strong>Milestone 7: P-4</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 3: P-4</strong></td>
<td><strong>Metric 7: P-4</strong></td>
</tr>
<tr>
<td>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
</tr>
<tr>
<td>Data Source: Project reports and Meeting minutes</td>
<td>Data Source: Project reports and meeting minutes</td>
</tr>
<tr>
<td>Goal: To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td>Goal: To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong></td>
<td><strong>Estimated Incentive Payment:</strong></td>
</tr>
<tr>
<td>$10,356.70</td>
<td>$24,538.37</td>
</tr>
<tr>
<td>Milestone 4: P-5: Disseminate findings, lessons learned, and best practices, to stakeholders</td>
<td>Milestone 8: P-5: Disseminate findings, lessons learned and best practices to stakeholders</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Metric 4: P-5: Report status, progress and lessons learned to stakeholders</td>
<td>Metric 8: P-5: Report status, progress and lessons learned to stakeholders</td>
</tr>
<tr>
<td>Goal: To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td>Goal: To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,356.70</td>
<td>$24,538.37</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estimated Outcome Amount:</th>
<th>Estimated Outcome Amount:</th>
<th>Estimated Outcome Amount:</th>
<th>Estimated Outcome Amount:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$41,426.81</td>
<td>$98,153.49</td>
<td>$106,215.85</td>
<td>$230,086.60</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $475,882.74
Title of Outcome Measure (Improvement Target): IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate

Performing Provider / TPI: Mental Health and Mental Retardation Authority of Harris County / 113180703

Unique RHP outcome identification number: 113180703.3.39

Outcome Measure Description:
IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate

- Numerator: The number of readmissions, for patients in the target population 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. If an index admission has more than 1 readmission, only the first is counted as a readmission.
- Denominator: The number of admissions, for patients in the target population 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of behavioral health and substance abuse and with a complete claims history for the 12 months prior to admission

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4: IT-3.8 5% decrease in re-admissions over baseline
- DY 5: IT-3.8 10% decrease in re-admissions over baseline

Rationale:
The goal of inpatient psychiatric/behavioral care is to stabilize an individual’s condition and facilitate successful reintegration into everyday life. For people with IDD/ASD and co-occurring mental illness, the supports to promote this goal must be coordinated by people who are knowledgeable in developmental disabilities, and often guided after discharge to help the person whose cognitive/intellectual abilities are often barriers to following through with aftercare. The lack of coordinated post-discharge plans and follow-through often result in re-hospitalizations or admission to very expensive and restrictive institutional care, which in Texas exceeds $177,624 per person, per year. The proposed model is intended to reduce the costs of healthcare by preventing these outcomes and demonstrating these benefits through the selected Category 3 measures.

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in establish baselines in DY 3 that will be used to evaluate the project’s outcomes in DY4 and DY5. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4).

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing outcomes. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:** Our local region has identified general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs), as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more successful linkage to post-discharge treatment and services that prevent readmissions. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>Milestone 1: P-1</th>
<th>Milestone 5: P-2</th>
<th>IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td>Percent of arrests per consumer pre/post psychosocial rehab intervention.</td>
<td>Goal: 5% decrease in admissions over baseline.</td>
</tr>
<tr>
<td>Metric 1: P-1: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information.</td>
<td>a. Numerator: The number of arrests per year per consumer after receiving psychosocial rehab intervention.</td>
<td>a. Numerator: The number of readmissions, for patients in the target population 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. If an index admission has more than 1 readmission, only the first is counted as a readmission.</td>
</tr>
<tr>
<td>Data Source: Meetings minutes and timelines.</td>
<td>b. Denominator: The number of arrests per year per consumer before receiving psychosocial rehab intervention.</td>
<td>b. Denominator: The number of admissions, for patients in the target population 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of behavioral health and substance abuse and with a complete claims history for the 12 months prior to admission.</td>
</tr>
<tr>
<td>Goal: To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way.</td>
<td>Data Sources: MHMRA, St. Joseph House.</td>
<td>Goal: 10% decrease in admissions over baseline.</td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment:**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,356.70</td>
<td>$24,538.37</td>
<td>$106,215.85</td>
<td>$230,086.60</td>
</tr>
<tr>
<td>Milestone 2: P-3</td>
<td>Milestone 6: P-3 Develop and test data systems</td>
<td>Metric 2: P-3: Develop and test systems to track baseline data for PSYCHOSOCIAL Data Source: Meeting minutes Goal: Establish method to track psychosocial rehab data across multiple organizations (e.g., MHMRA, St. Joseph’s House and police departments)</td>
<td></td>
</tr>
<tr>
<td>Milestone 6: P-3 Develop and test data systems</td>
<td>Metric 6: establish and test data collection protocol incorporating available law enforcement data Data Source: Law enforcement partners, project records Goal: Test and revise data collection system in order to measure of baseline by end of Yr. 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Estimated Incentive Payment: $ | Estimated Incentive Payment: $ |
| $10,356.70 | $24,538.37 |

| Milestone 3: P-4 | Milestone 7: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Project reports and Meeting minutes Goal: To improve processes and outcomes by implementing data-driven course corrections and innovations |
| Milestone 7: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Project reports and Meeting minutes Goal: To improve processes and outcomes by implementing data-driven course corrections and innovations |

| Estimated Incentive Payment: $ | Estimated Incentive Payment: $ |
| $10,356.70 | $24,538.37 |
### Regional Healthcare Partnership Plan

**Region 3**

<table>
<thead>
<tr>
<th>Milestone 4: P-5:</th>
<th>Milestone 8: P-5:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disseminate findings, lessons learned, and best practices, to stakeholders</td>
<td>Disseminate findings, lessons learned and best practices to stakeholders</td>
</tr>
<tr>
<td><strong>Metric 4: P-5:</strong> Report status, progress and lessons learned to stakeholders</td>
<td><strong>Metric 8: P-5:</strong> Report status, progress and lessons learned to stakeholders</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Meeting minutes</td>
<td><strong>Data Source:</strong> Meeting minutes</td>
</tr>
<tr>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
</tr>
</tbody>
</table>

#### Estimated Incentive Payment:

<table>
<thead>
<tr>
<th>Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,356.70</td>
<td>$24,538.37</td>
</tr>
</tbody>
</table>

#### Estimated Outcome Amount:

<table>
<thead>
<tr>
<th>Estimated Outcome Amount:</th>
<th>Estimated Outcome Amount:</th>
<th>Estimated Outcome Amount:</th>
<th>Estimated Outcome Amount:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$41,426.81</td>
<td>$98,153.49</td>
<td>$106,215.85</td>
<td>$230,086.60</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): **$475,882.74**
Title of Outcome Measure (Improvement Target): IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings

Unique RHP outcome identification numbers: 113180703.3.28

Performing Provider / TPI: Mental Health and Mental Retardation Authority of Harris County / 113180703

Outcome Measure Description:
IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings
- The number of individuals receiving ICC intervention who had a potentially preventable admission/readmission to a criminal justice setting during the demonstration years

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baselines for patients served
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT-9.1: Decrease in the number of individuals receiving ICC intervention who had a potentially preventable admission/readmission to a criminal justice setting during the demonstration years by 5% from baseline
- DY 5:
  - IT-9.1: Decrease in the number of individuals receiving ICC intervention who had a potentially preventable admission/readmission to a criminal justice setting during the demonstration years by 10% from baseline

Rationale:
The Process milestones were chosen as stated above in order to develop a strong collaborative team approach between the clinical staff, administrators, stake-holders, law-enforcement officers, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. The first steps in DY 2 will be project planning (P-1) then establishment of baselines (P-2) for the number of ICC interventions and the number of
arrests. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). In DY 3 a similar process will provide for accurate measurement of baselines from which to measure the success of the ICC intervention. In particular, we chose to add Process milestone P-3 Develop and test data systems in order to determine any new systemic changes in data collection that the collaborations may have allowed for that may not have been available in DY2.

We hope that the ratio of arrests to intervention will decrease as ICC teams and officers have more experience working collaboratively. At this time, we are not selecting a specific metric or percent of expected change. The rationale for determining this rate at a later time is that the base rate of arrests is expected to be low and the percent of change will need to appropriately reflect meaningful changes in arrests. ICC administrators and stakeholders will work in conjunction with the MHMRA Outcomes Department and the MHMRA Quality Improvement Department to determine an appropriate rate of change.

Once initial rates of change in DY 4 have been determined another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in reducing preventable mental health admissions and readmissions to criminal justice settings. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:**

We have selected preventable mental health admissions/readmissions to criminal justice setting as a measure because many of the recipients of ICC have a history of arrests and emergency calls to law enforcement. Without ICC, these calls would traditionally result in the dispatch of a law enforcement officer with limited mental health training/experience. Research has indicated non-trained officers may be more likely to arrest mentally ill patients, or interpret their behaviors as threatening, compared to trained officers. Therefore, we believe that the ICC expansion will result in better assessment and management of these individuals, which would result in fewer and more appropriate arrests. In recent surveys it has been noted that 25% of the inmates in Harris County Jail are receiving psychotropic medications. Further, more than 16% have histories of treatment within the public mental health system. In many instances, it appear likely that individuals with mental disorders are arrested and jailed at significant public expense when appropriate crisis-oriented mental health care could potentially avert criminalization of episodes of untreated mental disorder. It is also important to note that all patients have a right to be treated in the least-restrictive environment possible; ending interventions without detention ensure patients’ rights are respected and community treatment is more likely.
<table>
<thead>
<tr>
<th>Milestone</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td><strong>Project planning</strong> engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td><strong>Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</strong></td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td><strong>Meetings minutes and timelines</strong></td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td><strong>To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metric 1: P-1</th>
<th>Percent of arrests per consumer pre/post ICC intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a. Numerator:</strong></td>
<td>The number of arrests per year per consumer after receiving ICC intervention.</td>
</tr>
<tr>
<td><strong>b. Denominator:</strong></td>
<td>The number of arrests per year per consumer before receiving ICC intervention.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Source</th>
<th>MHMRA and police records</th>
</tr>
</thead>
</table>

| Goal | Establish baseline with the expected 1100 patients |

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 5:</strong> P-2: Establish Baselines</td>
<td><strong>Metric 5:</strong> P-2: Percent of arrests per consumer pre/post ICC intervention</td>
<td><strong>Metric 9:</strong> IT-9.1: Decrease in criminal justice arrests</td>
<td><strong>Metric 10:</strong> IT-9.1: Decrease in criminal justice arrests</td>
</tr>
<tr>
<td><strong>a. Numerator:</strong></td>
<td>The number of arrests per year per consumer after receiving ICC intervention.</td>
<td><strong>a. Numerator:</strong></td>
<td>The number of arrests per year per consumer after receiving ICC intervention.</td>
</tr>
<tr>
<td><strong>b. Denominator:</strong></td>
<td>The number of arrests per year per consumer before receiving ICC intervention.</td>
<td><strong>b. Denominator:</strong></td>
<td>The number of arrests per year per consumer before receiving ICC intervention.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Sources</th>
<th>MHMRA and police records</th>
</tr>
</thead>
</table>

| Goal | 5% reduction in arrests from baseline |
| Goal | 10% reduction in arrests from baseline |

<p>| Estimated Incentive Payment: | <strong>$18,339.38</strong> | <strong>$43,451.91</strong> | <strong>$188,084.26</strong> | <strong>$407,431.37</strong> |</p>
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 2: P-3:</strong> Develop and test data systems</td>
<td><strong>Milestone 6: P-3</strong> Develop and test data systems</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Metric 2: P-3:</strong> Develop and test systems to track baseline data for ICC</td>
<td><strong>Metric 6:</strong> establish and test data collection protocol incorporating available law enforcement data</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Meeting minutes</td>
<td><strong>Data Source:</strong> Law enforcement partners, project records</td>
<td>Goal: Establish method to track ICC data across multiple organizations (e.g., MHMRA and police departments)</td>
<td>Goal: Test and revise data collection system in order to measure of baseline by end of Yr. 3</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $18,339.38</td>
<td><strong>Estimated Incentive Payment:</strong> $43,451.91</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td><strong>Milestone 3: P-4:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities &lt;br&gt; <strong>Metric 3: P-4:</strong> Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles &lt;br&gt; <strong>Data Source:</strong> Project reports and Meeting minutes &lt;br&gt; <strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Milestone 7: P-4:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities &lt;br&gt; <strong>Metric 7: P-4:</strong> Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles &lt;br&gt; <strong>Data Source:</strong> Project reports and meeting minutes &lt;br&gt; <strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $18,339.38</td>
<td><strong>Estimated Incentive Payment:</strong> $43,451.91</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Related Category 1 or 2:</td>
<td>113180703.1.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline will be established in DY3 with the 1100 patients anticipated to be served</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
<tr>
<td><strong>Milestone 4: P-5:</strong> Disseminate findings, lessons learned, and best practices to stakeholders</td>
<td><strong>Milestone 8: P-5:</strong> Disseminate findings, lessons learned and best practices to stakeholders</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Metric 4: P-5:</strong> Report status, progress and lessons learned to stakeholders</td>
<td><strong>Metric 8: P-5:</strong> Report status, progress and lessons learned to stakeholders</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Meeting minutes</td>
<td><strong>Data Source:</strong> Meeting minutes</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>$18,339.38</td>
<td>$43,451.91</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $73,357.51</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $173,807.64</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $188,084.26</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $407,431.37</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $842,680.77
Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living

Unique RHP outcome identification numbers: 113180703.37 / Pass 2

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Outcome Measure Description:
IT-10.2: Activities of Daily Living: Demonstrate improvement in ADL scores, as measured by evidence based and validated assessment tool, for the target population.
- Numerator: Average current score minus average baseline score in the Supports Intensity Scale (SIS) for adults, and an instrument TBD for children
- Denominator: Average baseline score

Process Milestones:
- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:
- DY 4:
  - IT. 10.2: Rate 1: Improve functional status by 5 % over baseline scores for one domain of functional status
- DY 5:
  - IT 6.1: Rate 1: Improve functional status by 10 % over baseline scores for one domain of functional status

Rationale:
The ultimate goal of any patient-centered intervention is to improve the individual’s circumstances by empowering him/her and the family or other caregivers to resolve the immediate problem and future recurrences. To that end, it is important to determine if an
The proposed project will use the Supports Intensity Scale (SIS) that has been established for this purpose and normed on the target population. This scale is designed to measure an adult’s needs in various domains of daily life; it is sensitive to change as the person’s circumstances improve. The SIS is used nationally in several states and has been used internationally with the target population. A children’s version of the SIS is under development but may not be ready for use for this project. An alternative measure suitable for children with IDD will be selected after researching the options that are supported by research studies in this population.

The process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly-formed Outcome Management Department of MHMRA. As part of DY 2 process goals, the Outcome Management Department will complete literature reviews to identify relevant, empirically-validated, and empirically-based measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure for use with children.

Each person referred will be evaluated with the appropriate functional assessment tool, and, from this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements in the team’s interventions in order to maximize benefits for patients and families.

**Outcome Measure Valuation:** Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-10 Quality of Life/Functional Status as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, *i.e.* when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in greater independence and decreased reliance on more costly, less effective external systems, more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>113180703.2.8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD YR3</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Process Milestone 1 [P-1]: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information Goal: To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way Data Source: Meetings minutes, project flow charts and timelines</td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Process Milestone 6 [P-1]: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information Goal: To complete project planning process and implement Data Source: Meetings minutes, project flow charts and timelines</td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Process Milestone 2 P-2: Establish baseline Metric 1: Identify domains of patient satisfaction to be measured Goal: determine how baseline will be established for patient satisfaction domain Data Source: literature review</td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td>Process Milestone 7 [P-2]: Establish baseline Metric 1: Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction Goal: obtain baseline of satisfaction survey from patients receiving service Data Source: Clinical records; monthly management reports</td>
</tr>
<tr>
<td>Milestone 11: [IT-10.2]: Demonstrate improvement in ADL scores, as measured by evidence based and validated assessment tool, for the target population. Improvement Target: 5% improvement over baseline Data source: Patient/Individual Record Numerator: Average current score minus average baseline score. Denominator: Average baseline score</td>
<td>Milestone 12: IT-10.2: Demonstrate improvement in ADL scores, as measured by evidence based and validated assessment tool, for the target population. Improvement Target: 10% improvement over baseline Data source: Patient/Individual Record Numerator: Average current score minus average baseline score. Denominator: Average baseline score</td>
</tr>
</tbody>
</table>

Process Milestone 1 Estimated Incentive Payment: $7,801.25
Process Milestone 6 Estimated Incentive Payment: $18,483.69
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 3 [P-3]:** Develop and test data systems
**Metric 1:** Review satisfaction measures for use with the target population and their clinical teams
Goal: Identify/modify one instrument to test in Yr. 3
Data Source: Project record—summary of reviews

**Process Milestone 4 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
Goal: To improve processes and outcomes by implementing data-driven course corrections and innovations
Data Source: Project reports, QI reports

**Process Milestone 5 [P-5]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations
Data Source: Project reports, QI reports

**Process Milestone 6 [P-6]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations
Data Source: Project reports, QI reports

**Process Milestone 7 [P-7]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations
Data Source: Project reports, QI reports

**Process Milestone 8 [P-8]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations
Data Source: Project reports, QI reports

**Process Milestone 9 [P-9]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations
Data Source: Project reports, QI reports

**Process Milestone 10 [P-10]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations
Data Source: Project reports, QI reports

**Process Milestone 11 [P-11]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations
Data Source: Project reports, QI reports

**Process Milestone 12 [P-12]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations
Data Source: Project reports, QI reports

**Process Milestone 13 [P-13]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations
Data Source: Project reports, QI reports

**Process Milestone 14 [P-14]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations
Data Source: Project reports, QI reports

**Process Milestone 15 [P-15]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations
Data Source: Project reports, QI reports

**Process Milestone 16 [P-16]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations
Data Source: Project reports, QI reports

**Process Milestone 17 [P-17]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations
Data Source: Project reports, QI reports

**Process Milestone 18 [P-18]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
**Metric 1:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles
Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations
Data Source: Project reports, QI reports
### Activities of Daily Living

**RHP Performing Provider - MHMRA of Harris County**

**Related Category 1 or 2 Projects:** 113180703.3.37

**Starting Point/Baseline:** TBD YR3

<table>
<thead>
<tr>
<th>Year</th>
<th>Project Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td>Process Milestone 4 Estimated Incentive Payment: $7,801.25</td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td>Process Milestone 9 Estimated Incentive Payment: $18,483.69</td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
</tbody>
</table>

**Process Milestone 5 [P-5]:**
- Disseminate findings, including lessons learned and best practices, to stakeholders
- **Metric 1:** Report status, progress and lessons learned to stakeholders
- **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers

**Data Source:** management team minutes, RHP collaborations

**Process Milestone 5 Estimated Incentive Payment:** $7,801.26

**Process Milestone 10 [P-5]:**
- Disseminate findings, including lessons learned and best practices, to stakeholders
- **Metric 1:** Report status, progress and lessons learned to stakeholders
- **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies, and private providers

**Data Source:** management team minutes, RHP collaborations

**Process Milestone 10 Estimated Incentive Payment:** $18,483.67

**Year 2 Estimated Outcome Amount:** $39,006.26

**Year 3 Estimated Outcome Amount:** $92,418.43

**Year 4 Estimated Outcome Amount:** $100,009.71

**Year 5 Estimated Outcome Amount:** $216,642.77
Title of Outcome Measure (Improvement Target): IT-2.13 Other Admissions Rate: Rate of Admission into State Supported Institutional Care

Performing Provider / TPI: Mental Health and Mental Retardation Authority of Harris County / 113180703

Unique RHP outcome identification number: 113180703.3.38

Outcome Measure Description:
IT-2.13 Other Admissions Rate: Rate of Admission into State Supported Institutional Care

- Numerator: Number of admissions in DY among patients receiving services by program minus baseline
- Denominator: Number of baseline admissions

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4: IT-2.13 5% decrease in admissions over baseline
- DY 5: IT-2.13 10% decrease in admissions over baseline

Rationale:
The goal of inpatient psychiatric/behavioral care is to stabilize an individual’s condition and facilitate successful reintegration into everyday life. For people with IDD/ASD and co-occurring mental illness, the supports to promote this goal must be coordinated by people who are knowledgeable in developmental disabilities, and often guided after discharge to help the person whose cognitive/intellectual abilities are often barriers to following through with aftercare. The lack of coordinated post-discharge plans and follow-through often result in re-hospitalizations or admission to very expensive and restrictive institutional care, which in Texas exceeds $177,624.
per person, per year. The proposed model is intended to reduce the costs of healthcare by preventing these outcomes and demonstrating these benefits through the selected Category 3 measures.

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop effective care transition and aftercare follow up plans the team will be able to establish baselines in DY 3 that will be used to evaluate the project’s outcomes in DY4 and DY5.

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient outcomes. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:** Our local region has identified general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-2- Potentially Preventable Admissions, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more successful linkage to post-discharge treatment and services that prevent readmissions.
<table>
<thead>
<tr>
<th>Related Category 1 or 2:</th>
<th>113180703.2.9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be established with the 40 patients expected to be served in DY 3</td>
</tr>
</tbody>
</table>

**Year 2**
(10/1/2012 – 9/30/2013)

**Milestone 1: P-1:** Project planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

**Metric 1: P-1:** Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information

**Data Source:** Meetings minutes and timelines

**Goal:** To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way

**Year 3**
(10/1/2013 – 9/30/2014)

**Milestone 5: P-2:** Establish Baselines

**Metric 1:** P-2: Percent of admission to state supported institutions per consumer pre/post psychosocial rehab intervention

- **a. Numerator:** The number of admissions per year per consumer after receiving psychosocial rehab intervention.
- **b. Denominator:** The number of admissions per year per consumer before receiving psychosocial rehab intervention.

**Data Sources:** MHMRA, St. Joseph House

**Goal:** Establish baseline

**Year 4**
(10/1/2014 – 9/30/2015)

**Milestone 9: Metric 1IT-2.13: Other Admissions Rate: Rate of Admission into State Supported Institutional Care**

**Goal:** 5% decrease in admissions over baseline

**Numerator:** Number of admissions in DY among patients receiving services by program minus baseline

**b. Denominator:** Number of baseline admissions

**Data Source:** MHMRA and DADS records

**Year 5**
(10/1/2015 – 9/30/2016)

**Milestone 10: Metric 1IT-2.13 Other Admissions Rate: Rate of Admission into State Supported Institutional Care**

**Goal:** 10% decrease in admissions over baseline

**Numerator:** Number of admissions in DY among patients receiving services by program minus baseline

**b. Denominator:** Number of baseline admissions

**c. Data Source:** MHMRA and DADS records

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Estimated Incentive Payment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1IT-2.13</td>
<td>$10,356.70</td>
</tr>
<tr>
<td>2</td>
<td>$24,538.37</td>
</tr>
<tr>
<td>3</td>
<td>$106,215.85</td>
</tr>
<tr>
<td>4</td>
<td>$230,086.60</td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment:**

Regional Healthcare Partnership Plan  
Region 3  
2239
<table>
<thead>
<tr>
<th>Related Category 1 or 2:</th>
<th>113180703.2.9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be established with the 40 patients expected to be served in DY 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Milestone 2: P-3:</th>
<th>Milestone 6: P-3 Develop and test data systems</th>
<th>Milestone 6: P-3 Develop and test data systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 2: P-3:</td>
<td>Develop and test systems to track baseline data for PSYCHOSOCIAL.</td>
<td>Metric 1: establish and test data collection protocol incorporating available law enforcement data.</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Meeting minutes.</td>
<td>Data Source: Law enforcement partners, project records.</td>
</tr>
<tr>
<td>Goal:</td>
<td>Establish method to track psychosocial rehab data across multiple organizations (e.g., MHMRA, St. Joseph’s House and police departments).</td>
<td>Goal: Test and revise data collection system in order to measure of baseline by end of Yr. 3.</td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>$10,356.70</td>
<td>Estimated Incentive Payment:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 3: P-4:</th>
<th>Milestone 7: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 3: P-4:</td>
<td>Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Project reports and Meeting minutes.</td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>$10,356.70</td>
</tr>
<tr>
<td>Related Category 1 or 2:</td>
<td>MHMRA of Harris County</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be established with the 40 patients expected to be served in DY 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 4: P-5:** Disseminate findings, lessons learned, and best practices, to stakeholders  
**Metric 1: P-5:** Report status, progress and lessons learned to stakeholders  
**Data Source:** Meeting minutes  
**Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers  
**Estimated Incentive Payment:** $10,356.70

<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount:</th>
<th>Year 3 Estimated Outcome Amount:</th>
<th>Year 4 Estimated Outcome Amount:</th>
<th>Year 5 Estimated Outcome Amount:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$41,426.81</td>
<td>$98,153.49</td>
<td>$106,215.85</td>
<td>$230,086.60</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $475,882.74
Mental Health and Mental Retardation Authority of Harris County

Pass 3
Title of Outcome Measure (Improvement Target): IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Unique RHP outcome identification numbers: 113180703.3.18

Outcome Measure Description:

IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings

- The number of permanent members who had a potentially preventable admission/readmission to a criminal justice setting during the demonstration years

Process Milestones:

- **DY 2:**
  - P-1- Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baselines for patients served
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

- **DY 3:**
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

**DY 4:**
- IT-9.1: Decrease in the number of permanent members who had a potentially preventable admission/readmission to a criminal justice setting during the demonstration year by 5% from baseline

**DY 5:**
- IT-9.1: Decrease in the number of permanent members who had a potentially preventable admission/readmission to a criminal justice setting during the demonstration years by 10% from baseline

Rationale:

The Process milestones were chosen as stated above in order to develop a strong collaborative team approach between the clinical staff, administrators, stakeholders, law-enforcement officers, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. The first steps in DY 2 will be project planning (P-1) then establishment of baselines (P-2) for the number of permanent members and the number of arrests. The procedures for testing data collection will be evaluated using the Plan Do Study Act.
(PDSA) cycles (P-4). In DY 3 a similar process will provide for accurate measurement of baselines from which to measure the success of the psychosocial rehab intervention. In particular, we chose to add Process milestone P-3 Develop and test data systems in order to determine any new systemic changes in data collection that the collaborations may have allowed for that may not have been available in DY2.

We hope that the ratio of arrests to intervention will decrease as the enhancement and development of the St. Joseph House take place. At this time, we are not selecting a specific metric or percent of expected change. The rationale for determining this rate at a later time is that the base rate of arrests is expected to be low and the percent of change will need to appropriately reflect meaningful changes in arrests. St. Joseph House administrators and stakeholders will work in conjunction with the MHMRA Outcomes Department and the MHMRA Quality Improvement Department to determine an appropriate rate of change.

Once initial rates of change in DY 4 have been determined another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in reducing preventable mental health admissions and readmissions to criminal justice settings. This information can then be provided to clinic staff in order to produce the needed improvements.

**Outcome Measure Valuation:**

We have selected preventable mental health admissions/readmissions to criminal justice setting as a measure because many of the individuals in the St. Joseph’s House have a history of arrests. In recent surveys it has been noted that 25% of the inmates in Harris County Jail are receiving psychotropic medications. Further, more than 16% have histories of treatment within the public mental health system. In many instances, it appear likely that individuals with mental disorders are arrested and jailed at significant public expense when appropriate mental health care could potentially avert criminalization of episodes of untreated mental disorder. It is also important to note that all patients have a right to be treated in the least-restrictive environment possible; therefore, St. Joseph’s House is an intervention that would ensure patients’ rights are respected and community treatment is more likely.
### MHMRA of Harris County

<table>
<thead>
<tr>
<th>Related Category 1 or 2:</th>
<th>113180703.1.9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>Baseline will be determined in DY 3 with the patients entering the program, estimated to be about 20 patients in DY3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1: P-1:</strong> Project planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 5: P-2:</strong> Establish Baselines</td>
<td><strong>Milestone 9: OD-9:</strong> Right Care, Right Setting</td>
<td><strong>Milestone 10: OD-9:</strong> Right Care, Right Setting</td>
</tr>
<tr>
<td><strong>Metric 1: P-1:</strong> Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td><strong>Metric 1: Establish Baselines</strong></td>
<td><strong>Metric 1: IT-9.1:</strong> Decrease in criminal justice arrests</td>
<td><strong>Metric 1: IT-9.1:</strong> Decrease in criminal justice arrests</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Meetings minutes and timelines</td>
<td>a. Numerator: The number of arrests per year per consumer after receiving psychosocial rehab intervention</td>
<td>a. Numerator: The number of arrests per year per consumer after receiving psychosocial rehab intervention.</td>
<td>a. Numerator: The number of arrests per year per consumer after receiving psychosocial rehab intervention.</td>
</tr>
<tr>
<td><strong>Goal:</strong> To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way</td>
<td>b Denominator: The number of arrests per year per consumer before receiving psychosocial rehab intervention</td>
<td>b Denominator: The number of arrests per year per consumer before receiving psychosocial rehab intervention.</td>
<td>b Denominator: The number of arrests per year per consumer before receiving psychosocial rehab intervention.</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $25,291.30</td>
<td><strong>Estimated Incentive Payment:</strong> $60,613.71</td>
<td><strong>Estimated Incentive Payment:</strong> $198,711.91</td>
<td><strong>Estimated Incentive Payment:</strong> $430,040.92</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 2: P-3:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 2: P-3:</strong> Develop and test data systems</td>
<td><strong>Milestone 6: P-3 Develop and test data systems</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1: P-3:</strong> Develop and test systems to track baseline data for PSYCHOSOCIAL</td>
<td><strong>Metric 1: Establish and test data collection protocol incorporating available law enforcement data</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Meeting minutes</td>
<td><strong>Data Source:</strong> Law enforcement partners, project records</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> Establish method to track psychosocial rehab data across multiple organizations (e.g., MHMRA, St. Joseph’s House and police departments)</td>
<td><strong>Goal:</strong> Test and revise data collection system in order to measure of baseline by end of Yr 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $18,968.48</td>
<td><strong>Estimated Incentive Payment:</strong> $45,460.28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milestone 3: P-4:</td>
<td>Disseminate findings, lessons learned, and best practices, to stakeholders</td>
<td>Metric 4: P-5:</td>
<td>Report status, progress and lessons learned to stakeholders</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Meeting minutes</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
<td><strong>Data Source:</strong> Meeting minutes</td>
<td><strong>Goal:</strong> To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers</td>
</tr>
<tr>
<td>Metric 1: P-4:</td>
<td>Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td>Metric 1: P-4:</td>
<td>Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project reports and Meeting minutes</td>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Data Source:</strong> Project reports and Meeting minutes</td>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $25,291.30</td>
<td><strong>Estimated Incentive Payment:</strong> $60,613.71</td>
<td><strong>Estimated Incentive Payment:</strong></td>
<td><strong>Estimated Incentive Payment:</strong></td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
</tr>
<tr>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>$25,291.30</td>
<td>$60,613.71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td>Year 3 Estimated Outcome Amount:</td>
<td>Year 4 Estimated Outcome Amount:</td>
<td>Year 5 Estimated Outcome Amount:</td>
</tr>
<tr>
<td>$75,873.91</td>
<td>$181,841.12</td>
<td>$198,711.91</td>
<td>$430,040.92</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $886,467.86
Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.19

Outcome Measure Description:

IT-6.1: Percent improvement over baseline of patient satisfaction scores

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for the communication with provider domain as measured by the CAPHS survey

- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10% over baseline scores for the communication with provider domain as measured by the CAPHS survey
**Rationale:**

The Process milestones were chosen in order to develop a strong collaborative team approach among the clinical staff, administrators, physicians, Program Compliance Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. This initiative will permit MHMRA, the performing provider, to improve on previous efforts to measure patient experience, through selection of reliable, valid measures with external benchmarks (national norms). As part of DY 2 process goals, the Outcome Management department will review the measures selected for this project. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a local baseline for the patient satisfaction domain of “How Well their Doctors Communicate” by DY2.

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Measurement of patient experience is significant in that the degree of patient satisfaction could be a determinant of willingness to return to services and engage in ongoing care. Both the Adult Visit Survey and the Adult Twelve Month Survey versions of the CAHPS questionnaire will be employed. Every new patient referred for outpatient services will receive the Adult Visit Survey after the completion of their first outpatient visit then the Adult Twelve Month Survey version will be used yearly for ongoing patients.

**Outcome Measure Valuation:**

Our local region has identified specific community objectives and needs that are related to transforming the current health care delivery system toward a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on these objectives, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available
services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce preventable admissions and readmissions to psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.
<table>
<thead>
<tr>
<th>Milestone 1: P-1</th>
<th>Milestone 6: P-1</th>
<th>Milestone 11: OD-6</th>
<th>Milestone 12: OD-6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Patient Satisfaction</td>
<td>Patient Satisfaction</td>
</tr>
<tr>
<td>Metric 1: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td>Metric 6: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information</td>
<td>Metric 11: IT 6-1 Percent improvement over baseline of patient satisfaction scores</td>
<td>Metric 12: IT 6-1 Percent improvement over baseline of patient satisfaction scores</td>
</tr>
<tr>
<td>Data Source: Meetings minutes, project flow charts and timelines</td>
<td>Data Source: Meetings minutes, project flow charts and timelines</td>
<td>a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain</td>
<td>a. Numerator: Percent improvement in targeted patient satisfaction as measured by the CAPHS domain</td>
</tr>
<tr>
<td>Goal: To integrate stakeholder input in development of program plan</td>
<td>Goal: To complete project planning process and implement</td>
<td>b. Denominator: Number of patients who were administered the survey</td>
<td>b. Denominator: Number of patients who were administered the survey</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data Source: Patient survey</td>
<td>Data Source: Patient survey</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Goal: 5% increase over baseline</td>
<td>Goal: 10% increase over baseline</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**IT-6.1** Percent improvement over baseline of patient satisfaction scores

MHMRA of Harris County

**Related Category 1 or 2:** 113180703.1.10

**Starting Point/Baseline:** Baseline will be established in DY3 with the 25 patients anticipated to be served

**Estimated Incentive Payment:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
<td>Estimated Incentive Payment:</td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan

Region 3

2251
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,281.98</td>
<td>$12,258.32</td>
<td>$65,496.61</td>
<td>$142,383.93</td>
</tr>
</tbody>
</table>

**Milestone 2: P-2: Establish baseline**

**Metric 2: Identify domains of patient satisfaction to be measured**

**Data Source:** literature review

**Goal:** determine how baseline will be established for patient satisfaction domain

**Estimated Incentive Payment:** $5,281.98

---

**Milestone 7: P-2: Establish baseline**

**Metric 7: Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction**

**Data Source:** Clinical records; monthly management reports

**Goal:** obtain baseline of satisfaction survey from patients receiving service

**Estimated Incentive Payment:** $12,258.32

---

**Estimated Incentive Payment:** N/A

---

**Estimated Incentive Payment:** N/A

---

**Estimated Incentive Payment:** N/A
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 3: P-3:</strong> Develop and test data systems</td>
<td><strong>Milestone 8: P-3:</strong> Develop and test data systems</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Metric 3:</strong> Review satisfaction measures for use with the target population and their clinical teams</td>
<td><strong>Metric 8:</strong> Review satisfaction measures for use with the target population</td>
<td>Data Source: Project record—summary of reviews</td>
<td>Data Source: Project record—summary of reviews, completed surveys</td>
</tr>
<tr>
<td><strong>Goal:</strong> Identify/modify one instrument to test in Yr. 3</td>
<td><strong>Goal:</strong> Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment:**
- Year 2: $5,281.98
- Year 3: $12,258.32
- Year 4: N/A
- Year 5: N/A
<table>
<thead>
<tr>
<th>Year</th>
<th>Year</th>
<th>Year</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>Milestone 4: P-4:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td><strong>Milestone 9: P-9:</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Metric 4:</strong> Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td><strong>Metric 9:</strong> Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment:**
- **Year 2:** $5,281.98
- **Year 3:** $12,258.32
- **Year 4:** N/A
- **Year 5:** N/A
<table>
<thead>
<tr>
<th>113180703.3.19</th>
<th>IT-6.1</th>
<th>Percent improvement over baseline of patient satisfaction scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHMRA of Harris County</td>
<td>113180703</td>
<td></td>
</tr>
</tbody>
</table>

**Related Category 1 or 2:**

| 113180703.1.10 |

**Starting Point/Baseline:**

Baseline will be established in DY3 with the 25 patients anticipated to be served

<table>
<thead>
<tr>
<th>Milestone 5: P-5</th>
<th>Disseminate findings, including lessons learned and best practices, to stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 5:</strong></td>
<td>Report status, progress and lessons learned to stakeholders</td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td>management team minutes, RHP collaborations</td>
</tr>
<tr>
<td><strong>Goal:</strong></td>
<td>To disseminate information about the project and solicit input from stakeholders</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 10: P-5</th>
<th>Disseminate findings to stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metric 10:</strong></td>
<td>Report status, progress and lessons learned to stakeholders</td>
</tr>
<tr>
<td><strong>Data Source:</strong></td>
<td>management team minutes, RHP collaborations</td>
</tr>
<tr>
<td><strong>Goal:</strong></td>
<td>To disseminate information about the project and solicit input from stakeholders</td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

| $5,281.98 | $12,258.32 |

**Year 2 Estimated Outcome Amount:**

<table>
<thead>
<tr>
<th>Year 3 Estimated Outcome Amount:</th>
<th>Year 4 Estimated Outcome Amount:</th>
<th>Year 5 Estimated Outcome Amount:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,070.63</td>
<td>$45,460.28</td>
<td>$49,677.98</td>
</tr>
<tr>
<td>$107,510.23</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $217,719.12
**Title of Outcome Measure (Improvement Target):** IT-9.4: Other outcome improvement target: Percent decrease in psychiatric symptoms that provoke behavioral crises

**Unique RHP outcome identification numbers:** 113180703.3.29

**Performing Provider/TPI:** Mental Health and Mental Retardation Authority of Harris County/113180703

**Outcome Measure Description:** IT-9.4: Percent improvement over baseline of patient psychiatric symptoms using the BECK Depression Scale
- Numerator: Average change in BECK score across patients
- Denominator: Average prior score across patients

**Process Milestones:**
- **DY 2:**
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders
- **DY 3:**
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders

**Outcome Improvement Targets for each year:**
- **DY 4:**
  - IT 9.4: Rate 2: Improve patient psychiatric depressive symptoms by 5% over baseline scores
- **DY 5:**
  - IT 9.4: Rate 2: Improve patient psychiatric depressive symptoms by 10% over baseline scores for one domain of patient symptoms

**Rationale:**

The primary function of the proposed outpatient clinic for the vision-impaired is to reduce the behavioral/psychiatric symptoms that interfere and complicate medical interventions, provoke behavioral crises and result in inappropriate care in settings such as emergency departments, inpatient psychiatric units and jails. The proposed program is skilled in treating the target population and has selected the BECK Depression Inventory (BDI) to evaluate treatment outcomes. The BDI has been used extensively in research and clinical settings and is nationally...
normed on the target population of people co-occurring mental illness. The BDI is available for children and adults, allowing uniformity in how all of the program’s patients will be assessed.

Upon intake, each patient will be assessed using the BDI to establish baseline levels of symptoms. Patients will be reevaluated at 3 months, 6 months and 12 months to track progress. From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient clinical progress. This information can then be provided to clinic staff in order to modify treatment goals and interventions as needed.

**Outcome Measure Valuation:**

Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction and IT-9.4: Other outcome improvement target: Percent decrease in psychiatric symptoms that provoke behavioral crises as a targeted outcome for quality improvement goal. It is hypothesized, and supported by research literature, that patients with depressive symptoms and co-morbid health issues are at higher risk of complications in treatment of their health condition and tend to have poor outcomes. It is hoped that by addressing depressive symptoms along with co-morbid health issues, as described in this narrative, that patients will improve both their mental health symptoms and medical condition more effectively.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1 P-1:</strong> Project planning: engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 6: P-1:</strong> Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Milestone 11:</strong> IT 6.1 percent improvement over baseline of patient psychiatric symptoms as measured by the BECK.</td>
<td><strong>Milestone 12:</strong> IT 6.1 percent improvement over baseline of patient psychiatric symptoms as measured by the BECK.</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source:</strong> Meetings minutes, project flow charts and timelines</td>
<td><strong>Data Source:</strong> BECK</td>
<td><strong>Data Source:</strong> BECK</td>
</tr>
<tr>
<td><strong>Goal:</strong> To integrate stakeholder input in development of program plan</td>
<td><strong>Goal:</strong> To complete project planning process and implement</td>
<td><strong>Goal:</strong> 5% increase over baseline</td>
<td><strong>Goal:</strong> 10% increase in baseline</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $3,014.13</td>
<td><strong>Estimated Incentive Payment:</strong> $9,092.06</td>
<td><strong>Estimated Incentive Payment:</strong> $49,677.98</td>
<td><strong>Estimated Incentive Payment:</strong> $107,510.23</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>(10/1/2012 – 9/30/2013)</td>
<td>(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td><strong>Milestone 2: P-2:</strong> Establish baseline</td>
<td><strong>Milestone 7: P-2:</strong> Establish baseline</td>
</tr>
<tr>
<td><strong>Data Source:</strong> literature review</td>
<td><strong>Data Source:</strong> Clinical records; monthly management reports</td>
</tr>
<tr>
<td><strong>Goal:</strong> determine how baseline will be established for patient satisfaction domain</td>
<td><strong>Goal:</strong> obtain baseline of satisfaction survey from patients receiving service</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $3,014.13</td>
<td><strong>Estimated Incentive Payment:</strong> N/A</td>
</tr>
</tbody>
</table>

**Starting Point/Baseline:** Baseline will be established in DY3 with the 25 patients anticipated to be served.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 3 P-3:** Develop and test data systems  
**Data Source:** Project record—summary of reviews  
**Goal:** Identify/modify one instrument to test in Yr. 3

**Milestone 8: P-3** Develop and test data systems  
**Data Source:** Project record—summary of reviews, completed surveys  
**Goal:** Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3

**Estimated Incentive Payment:**  
Year 2: $3,014.13  
Year 3: $9,092.06  
Year 4: N/A  
Year 5: N/A
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 4 P-4</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td><strong>Milestone 9 P-9</strong> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td><strong>Data Source:</strong> Project reports including examples of how real time data has been used to guide continuous quality improvement</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Goal:</strong> To improve processes and outcomes by implementing data-driven course corrections and innovations</td>
<td><strong>Goal:</strong> To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Estimated Incentive Payment:**
- Year 2: $3,014.13
- Year 3: $9,092.06
- Year 4: N/A
- Year 5: N/A
### Outcome Measure: Percent decrease in psychiatric symptoms that provoke behavioral crises

- **RHP Performing Provider**: MHMRA of Harris County
- **TPI**: 113180703
- **Related Category 1 or 2**: 1.9

**Starting Point/Baseline**: Baseline will be established in DY3 with the 25 patients anticipated to be served

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal</strong></td>
<td>Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>Disseminate findings to stakeholders</td>
<td><strong>Metric 5</strong>: Report status, progress and lessons learned to stakeholders</td>
<td><strong>Metric 10</strong>: Report status, progress and lessons learned to stakeholders</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
<td>management team minutes, RHP collaborations</td>
<td>management team minutes, RHP collaborations</td>
<td><strong>Goal</strong>: To disseminate information about the project and solicit input from stakeholders</td>
<td><strong>Goal</strong>: To disseminate information about the project and solicit input from stakeholders</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment</strong>:</td>
<td>$3,014.13</td>
<td>$9,092.06</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount</strong>:</td>
<td>$15,070.63</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3 Estimated Outcome Amount</strong>:</td>
<td></td>
<td>$45,460.28</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4 Estimated Outcome Amount</strong>:</td>
<td></td>
<td></td>
<td>$49,677.98</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5 Estimated Outcome Amount</strong>:</td>
<td></td>
<td></td>
<td></td>
<td>$107,510.23</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**: $217,719.12
Methodist Willowbrook Hospital

Pass 1
Title of Outcome Measure (Improvement Target): IT 1.18 - Follow up after Hospitalization for Mental Illness

Performing Provider Name / TPI: Methodist Willowbrook Hospital / 140713201

Unique RHP outcome identification number(s): 140713201.3.1

Outcome Measure Description:
IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)
Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.
Our goal is that by year four we will have 60% with follow up within 30 days, and by year 5 we will have 80%.
Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.
As it is difficult to arrange appointments so close to discharge because of patient and physician factors, our goal is that by the fourth year we will have 40% follow up within seven days and by the fifth year, 50%.

Process Milestones:
- DY2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year:
- DY4: IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)
  - Improvement Target: 60% above baseline
- DY5: IT 1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)
  - Improvement Target: 80% above baseline

Rationale:
Process milestones in DY 2 are focused on training, education and partnership development. These efforts are largely external efforts focused on our medical staff, collaborating healthcare providers and community partners.
Process milestones in DY 3 are focused on establishing our baseline, factors that are driving utilization and establishing a process to follow up with patients post-discharge. These are largely internal efforts with our hospital based work teams.

Outcome Measure Valuation:
We have selected IT 1.18 as our quality outcome metric as we feel this is most important quality outcome to determine the success or impact of our project. Through a focused effort to follow up and coordinate the post discharge care needs of our targeted population we will demonstrate true
value to the community. Meaning, our targeted population will receive higher quality care in the correct care setting, all at a lower cost.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>140713201.2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>To be established in DY3</td>
</tr>
<tr>
<td><strong>Methodist Willowbrook</strong></td>
<td>140713201</td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR; Business Intelligence</strong></td>
<td><strong>Process Milestone 2 [P-2]: Establish baseline Data Source: EMR</strong></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $166,311</td>
<td>Process Milestone 2 Estimated Incentive Payment: $166,314</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $166,311</td>
<td>Year 3 Estimated Outcome Amount: $166,314</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**<br>(add outcome amounts over DYs 2-5): $1,130,912
OakBend Medical Center

Pass 1
Title of Outcome Measure (Improvement Target): IT-3.2 Congestive Heart Failure 30-Day Readmission Rate

Unique RHP Outcome Identification Number(s): 127303903.3.1

Outcome Measure Description:
This outcome will measure the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission. Given data limitations, only readmissions to the same facility will be included as part of each hospital’s rates.

Rationale:
The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. If the project is successful, then it will result in more effective management of chronic conditions, which in turn will result in the reduction of unnecessary readmissions. Congestive heart failure is an exemplar diagnosis for which effective disease management has been shown to reduce unnecessary hospital admissions. Therefore, the reduction in CHF admissions will be a reasonable metric by which to judge the effectiveness of this project.

Outcome Measure Valuation:
OBMC values each Category 3 outcome measure based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to effect each outcome.

In valuing this outcome measure, OBMC took into account the extent to which the reduction of potentially preventable CHF readmissions would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to achieve a reduction in CHF readmission rates.
<table>
<thead>
<tr>
<th><strong>127303903.3.1</strong></th>
<th><strong>3.IT-3.2</strong></th>
<th><strong>Congestive Heart Failure 30-Day Readmission Rate</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OAKBEND MEDICAL CENTER</strong></td>
<td><strong>127303903.1.1</strong></td>
<td><strong>127303903</strong></td>
</tr>
<tr>
<td><strong>Related Category 1 or 2 Projects:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</strong></td>
<td><strong>Process Milestone 2 [P-2]: Establish baseline rates.</strong></td>
</tr>
<tr>
<td></td>
<td>Process Estimate Incentive Payment: <strong>$38,287</strong></td>
<td>Outcomes Improvement Target 1 [IT-3.2]: Potentially Preventable Readmissions: Congestive Heart Failure 30 Day Readmission Rate (Standalone Measure) Baseline/Goal: 2% improvement over baseline of DY2. Data Source: EHR and/or claims. Reports from DSRIP database as patients are loaded. (OakBend data only).</td>
</tr>
<tr>
<td></td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment: $38,287</strong></td>
<td>Baseline/Goal: 5% improvement over baseline of DY2. Data Source: EHR and/or claims. Reports from DSRIP database as patients are loaded. (OakBend data only).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: <strong>$122,875</strong></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount (add incentive payments amounts from each milestone/outcome improvement target): <strong>$66,062</strong></td>
<td>Year 3 Estimated Outcome Amount: <strong>$76,574</strong></td>
<td>Year 4 Estimated Outcome Amount: <strong>$122,875</strong></td>
</tr>
<tr>
<td>**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): <strong>$559,341</strong></td>
<td>Year 5 Estimated Outcome Amount: <strong>$293,831</strong></td>
<td></td>
</tr>
</tbody>
</table>
**Title of Outcome Measure (Improvement Target):** IT-2.1 Congestive Heart Failure Admission Rate (CHF)

**Unique RHP Outcome Identification Number(s):** 127303903.3.2

**Outcome Measure Description:**
The outcome for this measure is the reduction of preventable readmissions for all non-maternal discharges of age 18 years and older with a principal diagnosis code for congestive heart failure. All readmissions are counted as outcomes except those that are considered planned.

**Rationale:**
The increase in access to primary care physician services will decrease the number of admissions for diseases that can be adequately managed like CHF.

**Outcome Measure Valuation:**
OBMC values each Category 3 outcome measure based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to effect each outcome.

In valuing this outcome measure, OBMC took into account the extent to which the reduction in readmissions for CHF would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to achieve this outcome.
### 3.IT-2.1

**Congestive Heart Failure Admission Rate (CHF)**

**OAKBEND MEDICAL CENTER**

<table>
<thead>
<tr>
<th>Starting Point/Baseline</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Outcome Improvement Target 1 [IT-2.1]:</strong> Potentially Preventable Admissions: Congestive Heart Failure Admission Rate (CHF) Baseline/Goal: 2% improvement over DY2 baseline. Base yet to be determined since the database build is not complete yet in order for us to pull the metrics.</td>
<td><strong>Outcome Improvement Target 2 [IT-2.1]:</strong> Potentially Preventable Admissions: Congestive Heart Failure Admission Rate (CHF) Baseline/Goal: 4% improvement over DY2 baseline. Data Source: EHR, Claims.</td>
<td><strong>Outcome Improvement Target 3 [IT-2.1]:</strong> Potentially Preventable Admissions: Congestive Heart Failure Admission Rate (CHF) Baseline/Goal: 6% improvement over DY2 baseline. Data Source: EHR, Claims.</td>
<td></td>
</tr>
<tr>
<td>Process 1 Estimated Incentive Payment: <strong>$42,940</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-2]:</strong> Establish baseline rates</td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment: $99,546</strong></td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment: $159,737</strong></td>
<td><strong>Outcome Improvement Target 3 Estimated Incentive Payment: $381,980</strong></td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR; Claims. Process 2 Estimated Incentive Payment: <strong>$42,940</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount (add incentive payments amounts from each milestone/outcome improvement target): <strong>$85,880</strong></td>
<td>Year 3 Estimated Outcome Amount: <strong>$99,546</strong></td>
<td>Year 4 Estimated Outcome Amount: <strong>$159,737</strong></td>
<td>Year 5 Estimated Outcome Amount: <strong>$381,980</strong></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $727,143**
**Title of Outcome Measure (Improvement Target):** IT-3.1 All Cause 30-Day Readmission Rate

**Unique RHP Outcome Identification Number(s):** 127303903.3.3

**Outcome Measure Description:**
The outcome for this measure is unplanned all cause 30-day readmission, IT-3.1. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned.

**Rationale:**
The expansion of specialty care capacity will promote and encourage patients to access care which will lead to better clinical outcomes for the community. OBMC took these potential effects into account when considering the appropriate incentive payment value for this project.

**Outcome Measure Valuation:**
OBMC values each Category 3 outcome measure based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to effect each outcome.

In valuing this outcome measure, OBMC took into account the extent to which the reduction in all cause readmissions would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to achieve decrease in all cause readmissions.
### 127303903.3

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>127303903.1.3</th>
<th>All Cause 30-Day Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline</td>
<td>July 2012</td>
<td></td>
</tr>
</tbody>
</table>

#### Process Milestone 1 [P-1]:
- **Project planning** – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

**Data Source:** Planning documentation. EHR, Claims, information pulled from newly created DSRIP database. Baseline # of specialists and specialty visits to be increased each year following DY2.

**Process 2**
- Estimated Incentive Payment: $46,243

#### Process Milestone 2 [P-2]:
- **Establish baseline rates.**

**Data Source:** EHR; Claims.

**Process 2**
- Estimated Incentive Payment: $46,243

### Year 2 (10/1/2012 – 9/30/2013)
- **Outcome Improvement Target 1 [IT-3.1]:** Potentially Preventable Readmissions: All Cause 30-Day Readmission Rate
  - **Baseline/Goal:** 1% improvement over DY2 baseline.
  - **Data Source:** EHR, Claims.

**Process 2**
- Estimated Incentive Payment: $107,204

### Year 3 (10/1/2013 – 9/30/2014)
- **Outcome Improvement Target 2 [IT-3.1]:** Potentially Preventable Readmissions: All Cause 30-Day Readmission Rate
  - **Baseline/Goal:** 2% improvement over DY2 baseline.
  - **Data Source:** EHR, Claims.

**Process 2**
- Estimated Incentive Payment: $172,025

### Year 4 (10/1/2014 – 9/30/2015)
- **Outcome Improvement Target 3 [IT-3.1]:** Potentially Preventable Readmissions: All Cause 30-Day Readmission Rate
  - **Baseline/Goal:** 3% improvement over DY2 baseline.
  - **Data Source:** EHR, Claims.

**Process 2**
- Estimated Incentive Payment: $411,363

### Year 5 (10/1/2015 – 9/30/2016)
- **Outcome Improvement Target 3 [IT-3.1]:** Potentially Preventable Readmissions: All Cause 30-Day Readmission Rate
  - **Baseline/Goal:** 3% improvement over DY2 baseline.
  - **Data Source:** EHR, Claims.

**Process 2**
- Estimated Incentive Payment: $411,363

### Year 2 Estimated Outcome Amount:
- $92,486

### Year 3 Estimated Outcome Amount:
- $107,204

### Year 4 Estimated Outcome Amount:
- $172,025

### Year 5 Estimated Outcome Amount:
- $411,363

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $783,078
Title of Outcome Measure (Improvement Target): IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS)

Performing Provider: OakBend Medical Center (OBMC) / 127303903.

Unique RHP Outcome Identification Number(s): 127303903.3.4

Outcome Measure Description:
- OakBend will control the cholesterol of the relevant patient population.

Rationale:
- Total blood cholesterol is directly related to the development of coronary artery disease (CAD) and coronary heart disease (CHD), with most of the risk being associated with low-density lipoprotein cholesterol (LDL-C). When LDL-C levels are high, cholesterol can build up within the walls of the arteries, causing atherosclerosis, the build-up of plaque. Hemorrhaging or clot formation can occur at the site of plaque build-up, blocking arteries and causing heart attack and stroke. Reducing cholesterol in patients with known heart disease is critically important, as treatment can reduce morbidity (heart attack and stroke) and mortality by as much as 40%. The National Cholesterol Education Program (NCEP) has established guidelines for managing cholesterol levels in patients with heart disease. The guidelines established the need for close monitoring of LDL cholesterol in patients with coronary heart disease and set a target for LDL-C of less than or equal to 100 mg/dL for such patients. Cholesterol screening and control depends on the combined efforts of patient, physician and organization. Lifestyle factors and new medications offer tangible means for reducing cholesterol and the risk of heart disease.

Outcome Measure Valuation:
- OBMC values each Category 3 outcome measure based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to effect each outcome.

In valuing this outcome measure, OBMC took into account the extent to which the control of cholesterol would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to achieve an increase in cholesterol control.
Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS)

**OAKBEND MEDICAL CENTER**

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>127303903.2.1</th>
<th>127303903</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline</strong></td>
<td>July 2012</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td>(10/1/2012 – 9/30/2013)</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. <strong>Data Source:</strong> Meeting Agendas, sign-in sheets, conference calls, presentations, email, EHR, claims data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process 2 Estimated Payment: $61,259</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong></td>
<td>(10/1/2013 – 9/30/2014)</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong> [P-2]: Establish baseline rates. <strong>Data Source:</strong> Meeting Agendas, sign-in sheets, conference calls, presentations, email, EHR, claims data</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1</strong> [IT-1.6]: Cholesterol management for patients with cardiovascular conditions a. <strong>Numerator:</strong> Number of patients who had each of the following during the reporting period: • Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed during the measurement year. • LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL. b. <strong>Denominator:</strong> Patients aged 18 to 75 years as of December 31 of the measurement year who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) from January 1 through November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process 1 Estimated Incentive Payment: $52,849</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong></td>
<td>(10/1/2014 – 9/30/2015)</td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1</strong> [IT-1.6]: Cholesterol management for patients with cardiovascular conditions c. <strong>Numerator:</strong> Number of patients who had each of the following during the reporting period: • Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed during the measurement year. • LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong></td>
<td>(10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1</strong> [IT-1.6]: Cholesterol management for patients with cardiovascular conditions d. <strong>Denominator:</strong> Patients aged 18 to 75 years as of December 31 of the measurement year who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) from January 1 through November 1 of the year prior to the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount</td>
<td>Year 3 Estimated Outcome Amount: $61,259</td>
<td>Year 4 Estimated Outcome Amount: $98,300</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>$52,849</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYS 2-5): $447,473*
Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization (Standalone Measure)

Unique RHP Outcome Identification Number(s): 127303903.3.5

Outcome Measure Description:
This outcome will focus on reducing ED admissions for patients with targeted conditions.

DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:

DY5:
IT-9.2 Reduce Emergency Department visits for target conditions. Reduce by 5% for DY 5.

Rationale:
If the project is successful, then it will result in improved access to care for patients with targeted conditions. By improving access to care and ensuring that patients receive the right care in the right setting, this project will reduce the inappropriate use of the Emergency Department to deliver the same care.

Outcome Measure Valuation:
OBMC values each Category 3 outcome measure based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to effect each outcome.

In valuing this outcome measure, OBMC took into account the extent to which the reduction of ED utilization would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to achieve a reduction in ED utilization.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>127303903.2.2</th>
<th>127303903</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P-1 Project planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- engage stakeholders, identify</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- current capacity and needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- resources, determine timelines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- document implementation plans.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source:</strong> Documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of semiannual meetings including</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- meeting agendas, slides from</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- presentations and/or meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>notes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>$99,092</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount</strong>&lt;br&gt;(add incentive payments amounts from each milestone/outcome improvement target): $99,092</td>
<td>$114,861</td>
<td>$184,312</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong>&lt;br&gt;(add outcome amounts over DYs 2-5): $839,012</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
OakBend Medical Center

Pass 2
**Title of Outcome Measure (Improvement Target):** IT-8.1 Timeliness of Prenatal/Postnatal Care

**Unique RHP Outcome Identification Number(s):** 127303903.3.6 / Pass 2

**Outcome Measure Description:**
The outcome for this measure is the percentage of deliveries of live births for which women receive certain key facets of prenatal and postpartum care.

**Rationale:**
This project is explicitly tied to postnatal care.

**Outcome Measure Valuation:**
OBMC values each Category 3 outcome measure based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, the time, effort, and clinical resources necessary to affect each outcome. The project will also strive to continuously provide quality service to the population.

In valuing this outcome measure, OBMC took into account the extent to which increases in key areas of prenatal and postnatal care would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to achieve this outcome.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>3.IT-8.1</th>
<th>3.IT-8.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline</td>
<td><strong>127303903</strong>.3.6</td>
<td><strong>127303903</strong>.2.3</td>
</tr>
<tr>
<td><strong>Oak Bend Medical Center</strong></td>
<td><strong>127303903</strong></td>
<td><strong>127303903</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>3.IT-8.1</strong>: Perinatal Outcomes: Timeliness of Prenatal/Postnatal Care</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 [P-1]:</td>
<td><strong>Metric 1</strong>: Rate 1: Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.</td>
<td></td>
</tr>
<tr>
<td>Project planning – engage</td>
<td><strong>Outcome Improvement Target 1</strong>: 20% of patients receive prenatal care visit in the first trimester</td>
<td></td>
</tr>
<tr>
<td>stakeholders, identify current</td>
<td><strong>Rate 2</strong>: Had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.</td>
<td></td>
</tr>
<tr>
<td>capacity and needed resources,</td>
<td><strong>Outcome Improvement Target 2</strong>: 30% of patients receive prenatal care visit in the first trimester</td>
<td></td>
</tr>
<tr>
<td>determine timelines and</td>
<td><strong>Rate 2</strong>: Had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.</td>
<td></td>
</tr>
<tr>
<td>document implementation plans.</td>
<td><strong>Outcome Improvement Target 3</strong>: 25% of postpartum patients will receive postpartum care on or between 21 and 56 days after delivery.</td>
<td></td>
</tr>
<tr>
<td>Data Source: Meeting Agendas,</td>
<td><strong>Data source</strong>: EHR, claims</td>
<td></td>
</tr>
<tr>
<td>sign-in sheets, conference calls,</td>
<td><strong>Outcome Improvement Target 2</strong>: Estimated Incentive Payment: $59,039</td>
<td></td>
</tr>
<tr>
<td>presentations, email, EHR, claims</td>
<td><strong>Outcome Improvement Target 4</strong>: Estimated Incentive Payment: $140,681</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated</td>
<td><strong>Outcome Improvement Target 4</strong>: 40% of patients receive prenatal care visit in the first trimester</td>
<td></td>
</tr>
<tr>
<td>Incentive Payment: $30,702.45</td>
<td><strong>Rate 2</strong>: Had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong> [P-2]:</td>
<td><strong>Outcome Improvement Target 4</strong>: 25% of postpartum patients will receive postpartum care on or between 21 and 56 days after delivery.</td>
<td></td>
</tr>
<tr>
<td>Establish baseline rates.</td>
<td><strong>Data source</strong>: EHR, claims</td>
<td></td>
</tr>
<tr>
<td>Data Source: Meeting Agendas,</td>
<td><strong>Outcome Improvement Target 5</strong>: Estimated Incentive Payment: $140,681</td>
<td></td>
</tr>
<tr>
<td>sign-in sheets, conference calls,</td>
<td><strong>Outcome Improvement Target 5</strong>: Percentage of Low Birth-weight births (CHIPRA/NQF)</td>
<td></td>
</tr>
<tr>
<td>presentations, email, EHR, claims</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated</td>
<td><strong>Outcome Improvement Target 5</strong>: Percentage of Low Birth-weight births (CHIPRA/NQF)</td>
<td></td>
</tr>
<tr>
<td>Incentive Payment: $30,702.45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Estimated Outcome Amount</td>
<td>Year</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------</td>
<td>------</td>
</tr>
<tr>
<td>2</td>
<td>$61,404</td>
<td>3</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYS 2-5): $533,591**

**Metric 1: Low birth weight**

a. Numerator: The number of babies born weighing <2,500 grams at birth

b. Denominator: All births
c. Data source: EHR, claims

Outcome Improvement Target: No more than 8% of birth will be of babies with low birth weight.

Estimated Incentive Payment: $59,039

Low Birth-weight births (CHIPRA/NQF # 1382)

Metric 1: Low birth weight

a. Numerator: The number of babies born weighing <2,500 grams at birth

b. Denominator: All births
c. Data source: EHR, claims

Outcome Improvement Target: No more than 8% of birth will be of babies with low birth weight.

Estimated Incentive Payment: $140,681

Regional Healthcare Partnership Plan

Region 3
Oakbend Medical Center
Pass 3
Title of Outcome Measure (Improvement Target): IT-3.4 Renal Disease 30-Day Readmission Rate

Unique RHP Outcome Identification Number(s): 127303903.3.7 / Pass 3

Outcome Measure Description:
The outcome for this measure is readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index renal disease, COPD, Congestive Heart Failure and Diabetes admissions.

Rationale:
OBMC has a relatively large population with the above diseases and part of the wellness program will be specifically targeted to these patients. In 2011, OBMC had 1,545 patients admitted with one of the above as their primary admitting diagnosis. There are more than triple that number who are admitted with these as a diagnosis secondary. Therefore, measuring the readmission rate for these disease specific illnesses will be a reasonable measure of this project’s success.

Outcome Measure Valuation:
OBMC values each Category 3 outcome measure based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to effect each outcome.

In valuing this outcome measure, OBMC took into account the extent to which the reduction in readmissions for these diagnoses would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to achieve this outcome.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]:</td>
<td></td>
<td><strong>Outcome Improvement Target 1</strong> [IT-3.4]:</td>
<td><strong>Outcome Improvement Target 2</strong> [IT-3.4]:</td>
<td><strong>Outcome Improvement Target 3</strong> [IT-3.4]:</td>
<td></td>
</tr>
<tr>
<td>Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td></td>
<td>Potentially Preventable Readmissions: Renal Disease 30-Day Readmission Rate (Standalone Measure)</td>
<td>Potentially Preventable Readmissions: Renal Disease 30-Day Readmission Rate (Standalone Measure)</td>
<td>Potentially Preventable Readmissions: Renal Disease 30-Day Readmission Rate (Standalone Measure)</td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1:</strong></td>
<td></td>
<td>Renal Disease 30-Day Readmission Rate</td>
<td>Renal Disease 30-Day Readmission Rate</td>
<td>Renal Disease 30-Day Readmission Rate</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target: 2% reduction in preventable readmissions</td>
<td></td>
<td>Data source: EHR, claims</td>
<td>Data source: EHR, claims</td>
<td>Data source: EHR, claims</td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong></td>
<td>$215,123.40</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong> [P-2]: Establish baseline rates.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong></td>
<td>$215,123.40</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong> Estimated Incentive Payment:</td>
<td>$89,761.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount:</th>
<th>Year 3 Estimated Outcome Amount:</th>
<th>Year 4 Estimated Outcome Amount:</th>
<th>Year 5 Estimated Outcome Amount:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$179,522.10</td>
<td>$215,123.40</td>
<td>$352,623.00</td>
<td>$839,439.15</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $1,586,708*
Rice Medical Center
Pass 1
**Title of Outcome Measure (Improvement Target):** IT-6.1.1 Percent improvement over baseline of patient satisfaction scores establishing patients are getting timely care, appointments and information

**Performing Provider:** Rice Medical Center

**TPI:** 212060201

**Unique RHP outcome identification number:** 212060201.3.1

**Outcome Measure Description:** Rice will measure patient satisfaction for the patients served in the East Bernard clinic, who will have increased access to an FP/OB under Project 1.1.2. Rice will use the CAHPS survey to establish if patients who use the clinic feel they are receiving timely appointments, care, and information.

**Process Milestones**
- DY 2: P-1; P-1.1
- DY 3: P-5; P-5.1
- DY 4: P-4; P-4.1

**Outcome Improvement Target for each year:**
- DY4: IT-6.1
- DY5: IT-6.1

**Rationale:** The low-income community members residing in East Bernard and the boundaries of the Rice Hospital District are presently underserved by physicians providing primary care and OB services, as is reflected by Colorado County’s designation as a HPSA. In seeking to improve access to care, it is important to measure the patients’ perspective on how effective efforts toward obtaining that goal have been. If they have been successful, the patient survey scores will apprise Rice of best practices (i.e. using after-hours, having primary care providers who also specialize in a particular type of care). If patient satisfaction with access to timely care, appointments, and information does not increase, then Rice will have learned the lesson that perhaps the infrastructure or administration of the clinic need to change.

**Outcome Measure Valuation:** The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This is Rice’s most valuable Category 3 project because Rice seeks to improve patient access to primary care through participating in DSRIP, and this outcome will measure how successful Rice’s efforts have been. Patient satisfaction leads to increased and
earlier use of the health care delivery system, and better overall patient outcomes and quality of life. For these reasons, this outcome is of high value to the community.
### Related Category 1 or 2 Outcome Project(s):

**212060201.1.1**

**Starting Point/Baseline:**
To be established DY3.

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Milestone 1 [P-1]:** Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Rice will identify the correct survey instrument, train providers on administering the survey, and begin educating patients on the hospital’s initiative to improve patient satisfaction. Process Milestone 1 Estimated Incentive Payment: $7,940

**Milestone 2 [P-2]:** Establish baseline rate Data Source: Using the HCAHPS standardized survey instrument, Rice will establish the average East Bernard Clinic patient satisfaction scores for all patients surveyed. Process Milestone 2 Estimated Incentive Payment: $9,203

**Outcome Improvement Target 1**

- IT 6.1(1): Establish if East Bernard Clinic patients are getting timely care, appointments and information.
- Improvement Target: Expect 5% increase of patient satisfaction over baseline
- Data Source: Patient survey

**Outcome Improvement Target 1 Estimated Incentive Payment:** $14,768

**Outcome Improvement Target 2**

- IT 6.1(1): Establish if East Bernard Clinic patients are getting timely care, appointments and information.
- Improvement Target: Expect 10% increase of patient satisfaction over baseline
- Data Source: Patient survey

**Outcome Improvement Target 2 Estimated Incentive Payment:** $35,314

**Year 2 Estimated Milestone Bundle Amount:** $7,940

**Year 3 Estimated Milestone Bundle Amount:** $9,203

**Year 4 Estimated Milestone Bundle Amount:** $14,768

**Year 5 Estimated Milestone Bundle Amount:** $35,314

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $67,225
**Title of Outcome Measure (Improvement Target):** IT 6.1(1) – Percent improvement over baseline of patient satisfaction scores - timeliness of appointments, care, and information

**Unique RHP outcome identification number:** 212060201.3.2

**Performing Provider:** Rice Medical Center

**TPI:** 212060201

**Outcome Measure Description:**
Rice will engage in CAHPS patient surveys to measure the satisfaction of patients who have been entered into the ImmTrack system. Through expanding its use of Immunization Tracking, Rice will be able to communicate with patients about their immunization due dates and options. Additionally, Rice can use the data it collects to assure that patients do not receive duplicative immunization shots. This service will remove some of the burden on Rice’s hospital and clinic patients to remember when their immunizations are due, and if they have already updated them. Additionally, Rice can target populations that are especially at risk for flu and assure that they are seen early in the flu season (i.e. elderly, children, individuals with weak immune systems), which will improve these patients’ overall quality of life and satisfaction with the health care and information they receive from their provider. These improvements are intended to improve patients’ satisfaction with the timeliness of their appointments, care, and information from their provider.

**Starting Point/Baseline:**
Rice does not currently measure patient satisfaction scores in the domain of timeliness of appointments, care and information.

**Rationale:**
Colorado County has a high rate of preventable hospital stays (higher than Texas and Harris County), a high rate children living in poverty (higher than Texas and Harris County) and a high rate of poor physical health days (higher than Texas and Harris County). Children, the elderly, and those in poor health are especially at risk for being admitted to the hospital for the flu, so tracking who has been immunized in the community may help Rice reach out to those most at risk to assure that they receive their flu shot. According to the Planning Protocol, “Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.”

**Project Valuation:**
The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This outcome’s value is based upon the importance of obtaining patients’ perspective on their health care provision and outcomes in our effort to transform the delivery system. Additionally, this project will touch the vast majority of Rice’s patients.
| Process Milestone 1 [P-1] Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Rice will identify the correct survey instrument, train providers on administering the survey, and begin educating patients on the hospital’s initiative to improve patient satisfaction. Process Milestone 1 Estimated Incentive Payment $2,382 | Process Milestone 2 [P-2] Establish baseline rate Data Source: Use the relevant CAHPS survey to establish the average patient satisfaction score for patients seen in Colorado County clinics, measuring the timeliness of appointments, care, and information. Process Milestone 2 Estimated Incentive Payment $2,761 | Improvement Milestone 1 [IT-6.1] Improve Colorado County clinics’ patient satisfaction scores in the domain of timely appointments, care, and information Baseline/Goal: Improve by 10% over baseline Data Source: Patient survey Outcome Improvement Target 1 Estimated Incentive Payment: $4,430 | Improvement Milestone 2 IT 6.1.1 Improve Colorado County clinics’ patient satisfaction scores in the domain of timely appointments, care, and information Baseline/Goal: Improve by 15% over baseline Data Source: Patient survey Outcome Improvement Target 2 Estimated Incentive Payment: $10,594 |

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $20,167</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life

Performing Provider: Rice Medical Center

TPI: 212060201

Unique RHP Outcome identification number: 212060201.3.3

Outcome Measure Description:

The outcome of the Chronic Disease Outreach project will be to accomplish improvement in quality of life scores over the life of the Waiver for Rice community members identified as at-risk or suffering from chronic conditions such as diabetes, high blood pressure, and COPD. Expected challenges in attaining this outcome include recruiting staff for the clinic, negotiating space for the clinic, reaching out to traditionally underserved communities, engaging in effective patient education, and doing so with limited resources.

Process Milestones:

• P-1 Project Planning; P-2 Establish baseline QoL scores for chronically ill targeted patients

Outcome Improvement Targets for each year:

IT-10.1 Quality of Life - demonstrating annual increase

Rationale:

Colorado County has a high rate of morbidity and mortality (both higher than Harris County), poor physical health days (higher than Texas and Harris County), and premature death (higher than Texas and Harris County). Colorado County residents will benefit from increased quality and quantity of interventions for their chronic diseases. Improved management of these conditions will lead to improved quality of life (as measured by an evidence based and validated assessment tool) for the patients.

Outcome Measure Valuation:

The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project is valued to reflect the importance of maintaining quality of life for patients suffering from chronic disease, which has a ripple effect of improving their family and friends’ quality of life.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>212060201.2.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be established in DY3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Milestone 1** [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
   Data Source: Identify a valid and evidence-based instrument through which to measure the targeted patients’ quality of life (chronic disease sufferers in the 3 areas Rice identifies through Project 2.2.2) | **Milestone 2** [P-2] Establish a baseline.  
   Data Source: Survey results  
   Milestone 2 Estimated Incentive Payment: $5,522 | **Outcome Improvement Target 1** [IT 10.1] Quality of Life  
   Goal: Demonstrate improvement in quality of life scores for identified Colorado County patients (5% over baseline)  
   Data Source: Survey results  
   Outcome Improvement Target 1 Estimated Incentive Payment: $8,861 | **Outcome Improvement Target 2** [IT 10.1] Quality of Life  
   Goal: Demonstrate improvement in quality of life scores for identified Colorado County patients (10% over baseline)  
   Data Source: Survey results  
   Outcome Improvement Target 2 Estimated Incentive Payment: $21,288 |

<table>
<thead>
<tr>
<th>Milestone 1 Estimated Incentive Payment: $4,764</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $4764</td>
<td>Year 3 Estimated Milestone Bundle Amount: $5522</td>
<td>Year 4 Estimated Milestone Bundle Amount: $8861</td>
<td>Year 5 Estimated Milestone Bundle Amount: $21,188</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $ 40,335*
Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes Care: HbA1c poor control (>9.0%)

Performing Provider: Rice Medical Center

TPI: 212060201

Unique RHP Outcome Identification number: 212060201.3.4

Outcome Measure Description:
Rice will implement a Certified Diabetes Teaching Center for patients in Colorado County.

Through implementing a Certified Diabetes Teaching Center, Rice aims to improve the percentage of patients in Colorado County with uncontrolled blood sugar (IT1.10). The Center will accomplish this by educating the diabetic community on diabetes medication and diet management tactics, leading to better control of blood sugar. Patient education, follow-up, and management will result in better overall health outcomes for the targeted population, including increased quality of life, reduced use of acute care, and slower progression of this chronic disease. Achieving this outcome will require Rice to not only communicate with the target population, but to affect their lifestyle choices. Patients will need to reduce poor eating habits, increase physical activity, and manage their medications (when applicable), which Rice cannot force patients to do on a regular basis.

Rice intends to reach out to the community through innovative methods (including social media, creating coalitions, and other methods of community outreach) to create support networks and community engagement in accomplishing this outcome, which is meant to benefit individuals at-risk and the community as a whole.

Process Milestones:

- DY2: P-1; P-1.1
- DY3: P-3; P-3.1

Outcome Improvement Targets for each year:

- DY4: I-6; I-6.1
- DY5: I-8; I-8.1

Rationale:
Colorado County has a high rate of preventable hospital stays (higher than Texas and Harris County) and at least 15% of the county’s community does not receive any diabetes screening. Coupled with the high rate of obesity and inactivity in Colorado County (equal to and higher than Texas, respectively), there is good reason to believe that uncontrolled blood sugar for diabetics is a cause of the County’s high rate of potentially preventable admissions. Achieving this outcome domain will have positive effects on the health outcomes for patients and the cost of delivering health care for Rice Medical Center.
**Outcome Measure Valuation:**
The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This particular project is valued as Rice’s second highest value outcome due to the importance of controlling blood sugar and preventing hospital admissions for diabetics with uncontrolled blood sugar. Hospital admissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Additionally, they create an increased cost burden on the health care delivery system, which affects the entire community. Achieving this outcome will take considerable and concerted effort and investment in infrastructure, but the outcome will justify the expense.
<table>
<thead>
<tr>
<th>212060201.3.4</th>
<th>3.IT-1.10</th>
<th>DIABETES CARE: HBA1C POOR CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rice</strong></td>
<td>212060201</td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 1 or 2 Project(s):</strong></td>
<td><strong>212060201.2.3</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>To be established in DY3.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-1]</strong> Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. (Rice will determine how to give effect to this outcome (increasing blood sugar control among the diabetic population in Colorado County) through the Certified Diabetes Teaching Center, using evidence-based and innovative methods for outreach and engagement.) Data Source: Information from discussions/interviews with primary and community health care providers, city and county governments, charities, faith based organizations and other community based helping organizations. Process Milestone 1 Estimated Incentive Payment: $4,367</td>
<td><strong>Process Milestone 2 [P-2]</strong> Establish a baseline. Metric: Rice will determine the number of diabetic patients it currently treats with controlled blood sugar levels Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $5,062</td>
<td>**Outcome Improvement Target 1 – [IT-1.10] Diabetes Care: HbA1c poor control Improvement Target: Improve HbA1c control &gt; 9% in the Colorado County diabetic population by 5% over baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $8,122</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount:** $4,367  
**Year 3 Estimated Milestone Bundle Amount:** $5,062  
**Year 4 Estimated Milestone Bundle Amount:** $8,122  
**Year 5 Estimated Milestone Bundle Amount:** $19,422

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $36,973
Rice Medical Center
Pass 3
Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores: (3) patient’s rating of doctor access to specialist.

Performing Provider: Rice Medical Center

TPI: 212060201

Unique RHP Outcome ID: 212060201.3.5

Outcome Measure Description:
By implementing telemedicine in its hospital, Rice will increase its patients’ satisfaction with their and their doctors’ access to specialists. Rice will measure the satisfaction of all its patients in this domain, with the expected outcome of an increase in satisfaction as the telemedicine program expands.

Starting Point/Baseline:
Rice currently only measures patient satisfaction based on whether the hospital meets all of a patient’s healthcare needs.

Rationale:
Colorado County is a rural community. It can be very difficult for patients to access specialists, often having to travel long distances. Likewise, it is difficult for patient’s primary care physicians to coordinate with specialists for consultation and referral from a rural community. Patient satisfaction will increase when patients have closer and more immediate access to specialty care for consultations and referrals, especially as this is expected to result in improved patient outcomes.

Project Valuation:
The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. The value of this project is based on Rice’s belief that patient satisfaction leads to increased and earlier use of the health care delivery system, and better overall patient outcomes and quality of life. The capability to engage in telehealth and telemedicine will allow Rice to provide a broader range of treatment and diagnostic services to its patients, removing the need for those patients to travel to urban areas to access care and allowing for quicker access to often crucial health information. The telemedicine program can continually expand as Rice is able to identify additional specialist providers to participate in the program; thus, the potential impact for the satisfaction with their access to specialty-related information, care, and appointments for patients in Rice’s community will only grow over time. According to the Region’s County Health Rankings, Colorado County has a higher rate of premature death, poor physical health days, low birth weight, and adult obesity than the statewide average. Each of these statistics can be tied to conditions requiring specialty care
that may not be available in Colorado County, supporting Rice’s initiative to increase access to needed care and decrease the burden on patients by implementing a telemedicine program. For these reasons, this outcome is of high value to the community and Rice valued the outcome accordingly.
### Patient Satisfaction with Patients’ Ratings of Their Doctor Access to Specialist

**Rice**

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Outcome Project(s):</th>
<th>212060201.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>To be established in DY3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning.</td>
<td><strong>Process Milestone 2 [P-2]:</strong> Establish a baseline.</td>
<td><strong>Outcome Improvement Target 1 [IT 6.1(3)]:</strong> Percent Improvement Over Baseline Of Patient Satisfaction Scores: Establish an increase in Rice’s patients’ ratings of their doctor access to specialist.</td>
<td><strong>Outcome Improvement Target 2 [IT 6.1(3)]:</strong> Percent Improvement Over Baseline Of Patient Satisfaction Scores: Establish an increase in Rice’s patients’ ratings of their doctor access to specialist.</td>
</tr>
<tr>
<td><strong>Metric 1:</strong> Rice will identify the correct survey instrument, train providers on administering the survey, and begin educating patients on the hospital’s initiative to improve patient satisfaction.</td>
<td><strong>Metric 1:</strong> Using the HCAHPS standardized survey instrument, Rice will establish the average patient rating concerning their doctor access to specialists.</td>
<td><strong>Metric 1:</strong> X percent improvement in targeted patient ratings. Improvement Target: TBD</td>
<td><strong>Metric 1:</strong> X percent improvement in targeted patient ratings. Improvement Target: TBD</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Documentation of trainings and communication to patients regarding hospital’s initiative to improve patient satisfaction.</td>
<td><strong>Data Source:</strong> Survey results</td>
<td><strong>Data Source:</strong> Survey results</td>
<td><strong>Data Source:</strong> Survey results</td>
</tr>
<tr>
<td><strong>Process Milestone 2 Estimated Incentive Payment:</strong> $41,111</td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong> $61,667</td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong> $135,667</td>
<td></td>
</tr>
</tbody>
</table>

| Year 2 Estimated Milestone Bundle Amount: $41,111 | Year 3 Estimated Milestone Bundle Amount: $41,111 | Year 4 Estimated Milestone Bundle Amount: $61,667 | Year 5 Estimated Milestone Bundle Amount: $135,667 |

**Total Estimated Incentive Payments for 4-Year Period (add milestone bundle amounts over Years 2-5):** $279,556
Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores: (5) patient’s overall health status/functional status.

Performing Provider: Rice Medical Center

TPI: 212060201

Unique RHP Outcome ID: 212060201.3.6

Outcome Measure Description:
By establishing a new primary care clinic in Walls, Texas, Rice will increase the overall health and well-being of patient populations in this community. Rice will measure the satisfaction of all its patients in this domain, with the expected outcome of an increase in satisfaction as the primary care clinic is expanded and/or implemented.

Process milestones:

- In DY2, Rice will train staff in administering the HCAHPS to clinic patients in order to measure their level of satisfaction with their current access to primary care appointments, information, and care
- In DY3, Rice will establish a baseline of patient satisfaction scores in the Wallis clinic, in order to measure improvement going forward.

Starting Point/Baseline:

Rice is not currently measuring patients’ satisfaction with their overall health.

Rationale:

Wallis, Texas is a rural community. It can be very difficult for patients to access primary care, and they often must travel long distances to obtain simple services. Patient satisfaction and overall health will increase when patients have closer and more immediate access to primary care, especially as this is expected to result in improved patient outcomes. Patient satisfaction is important because satisfied patients are more likely to keep regular appointments with their PCPs and heed their providers’ advice.

Project Valuation:

The valuation of each Rice project takes into account the degree to which the project accomplishes the triple aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. The value of this project is based on Rice’s belief that patient satisfaction leads to increased and earlier use of the health care delivery system, and better overall patient outcomes and quality of life. Improved patient outcomes are linked to decreased costs of providing care over the long term, and the savings can be redirected into improving the overall quality and quantity of services in the local community. The residents of Wallis have no local primary care services. Wallis is located in Austin County (neighbor to
Colorado County, where Rice Medical Center is located), and its ratio of patients to primary care physicians is over 4 almost 5 times that of the statewide average (6758:1 and 1378:1, respectively). The population of Austin County, including Wallis, suffers from a higher rate of poor physical and mental health days and preventable hospitals stays than the statewide average. There is logically a connection between the paucity of primary care providers in Austin County and the high incidence of poor health in the community. Rice believes that opening a local clinic will go far towards improving the health of the Wallis community, and as a consequence improve patients’ satisfaction with their overall health/functional status. For these reasons, this outcome is of high value to the community and Rice valued the outcome accordingly.
### Percent Improvement over Baseline of Patient Satisfaction Scores

**Rice Medical Center**

**212060201.3.6**

**Starting Point/Baseline:** To be established in DY3.

<table>
<thead>
<tr>
<th>Year</th>
<th>Process Milestone 1 [P-1]: Project planning.</th>
<th>Process Milestone 2 [P-2]: Establish a baseline.</th>
<th>Outcome Improvement Target 1 [IT 6.1(5)] – Percent Improvement Over Baseline Of Patient Satisfaction Scores: Establish an increase in Rice’s patients’ ratings of their overall health.</th>
<th>Outcome Improvement Target 1 [IT 6.1(5)] – Percent Improvement Over Baseline Of Patient Satisfaction Scores: Establish an increase in Rice’s patients’ ratings of their overall health.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Rice will identify the correct survey instrument, train providers on administering the survey, and begin educating patients on the hospital’s initiative to improve patient satisfaction. Data source: documentation of staff training in selected survey and communication with clinic patients regarding the initiative to improve patient scores. Process Milestone 1 Estimated Incentive Payment: $82,222</td>
<td>Using the HCAHPS standardized survey instrument, Rice will establish the average patient rating concerning their overall health. Data Source: Survey results. Process Milestone 2 Estimated Incentive Payment: $82,222</td>
<td>Metric 1: X percent improvement in targeted patient ratings Improvement Target: TBD Data Source: Survey results. Outcome Improvement Target 1 Estimated Incentive Payment: $123,333</td>
<td>Metric 1: X percent improvement in targeted patient ratings Improvement Target: TBD Data Source: Survey results. Outcome Improvement Target 1 Estimated Incentive Payment: $271,333</td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td></td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $82,222</td>
<td>Year 3 Estimated Milestone Bundle Amount: $82,222</td>
<td>Year 4 Estimated Milestone Bundle Amount: $123,333</td>
<td>Year 5 Estimated Milestone Bundle Amount: $271,333</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $559,111
Title of Outcome Measure (Improvement Target): IT- 2.7:

Reduce Potentially Preventable Admissions Related to Short-term Diabetes Complications

Performing Provider: Rice Medical Center

TPI: 212060201

Unique RHP Outcome ID: 212060201.3.7

Outcome Measure Description:

By establishing an urgent care clinic in its hospital facility at which non-emergent patients can seek time-sensitive care, Rice will reduce the number of Potentially Preventable Admissions for Short-Term Diabetes Complications by the end of the Waiver.

Starting Point/Baseline: Approximately 68% of patients presenting for care at Rice’s Emergency Department are not truly emergent. Many of those patients, if seen in the ED, will ultimately be admitted into the hospital. By redirecting these patients to a more appropriate care setting for treatment, Rice expects a reduction in the rate of PPAs, with specific impact targeted for diabetes short-term complications.

Rationale:

Rice currently experiences serious overutilization of its Emergency Department. This is due in large part to the lack of alternatives for urgent patients who need time-sensitive care, but not the same level of care provided by the Emergency Department. Many times when patients are admitted to the ED, they are ultimately admitted as inpatients in the hospital, especially if they do not have a PCP in the community. By providing a clearly superior alternative to the Emergency Department (and a hospital inpatient stay), this urgent care clinic project will reduce the number of PPAs in Rice’s hospital facility. With 71% of Rice’s non-emergent ED encounters being Medicaid-eligible or uninsured, and 36% of overall hospital encounters being Medicaid/uninsured, the local and regional cost of delivering care will benefit from a reduction in inappropriate ED usage and the resulting PPAs. Rice selected short-term diabetes complications because these inpatient stays are often quite costly, and can be prevented if patients are given appropriate interventions (and follow the medical advice they are given) outside of the hospital setting. It is important to reduce the rate of acute complications from diabetes, which can lead to devastating consequences like amputation, blindness, and kidney failure. Rice currently treats 535 patients who are diagnosed with diabetes, but expects that there are many more patients without a diagnosis who are suffering from complications (especially in light of the fact that 1 in 3 adults in Colorado County are obese), and could end up admitted to the hospital without more appropriate interventions like the Urgent Care Center.

Project Valuation:
The valuation of each Rice project takes into account the degree to which the project accomplishes the triple aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. The value of this project is based on Rice’s belief that appropriate utilization of emergent care will result in better overall patient outcomes and quality of life, and a reduction in preventable hospital admissions for patients with chronic diseases, including diabetes. Many of the patients Rice treats each year either do not have access to clinic services in the community (due to a provider shortage, an inconvenience work schedule, or inability to travel, for example) or feel that they cannot access affordable care. These patients are often inclined to wait until their conditions worsen to the point of being emergent before seeking care and then end up admitted into the hospital, which is detrimental to their overall health, quality of life, and the systemic cost of delivering. Rice wishes to implement innovative solutions to the problems facing rural, indigent patients, and this urgent care clinic (located conveniently nearby the ED) is one way to provide patients an alternative to accessing care in the ED and risking admission into the hospital. For these reasons, this outcome is of high value to the community.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Outcome Project(s):</th>
<th>212060201.1.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be established in DY3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning.</td>
<td><strong>Process Milestone 2 [P-2]:</strong> Establish a baseline.</td>
<td><strong>Outcome Improvement Target 1 [IT-2.7]:</strong> PPAs: Diabetes Short Term Complications</td>
<td><strong>Outcome Improvement Target 2 [IT-2.7]:</strong> PPAs: Diabetes Short Term Complications</td>
</tr>
<tr>
<td><strong>Metric 1:</strong> Documentation of resources identified, stakeholders identified, and implementation plans. Determine best practices for redirecting patients and effecting a reduction in the use of the ED for non-emergent conditions, which is expected to reduce PPAs in general, and with specific impact on diabetes short-term complications that can be treated in an outpatient setting.</td>
<td><strong>Metric 1:</strong> Number of patients admitted into the hospital for diabetes short-term complications.</td>
<td><strong>Metric 1:</strong> X% reduction Improvement Target: Rice seeks to reduce the rate of diabetes short-term complications PPAs by 3% from the baseline established in DY3. Numerator: Targeted PPAs in DY 4 Denominator: Targeted PPAs in DY 3 Data Source: EHR; hospital admission records</td>
<td><strong>Metric 1:</strong> X% reduction Improvement Target: Rice seeks to reduce the rate of diabetes short-term complications PPAs by 6% from the baseline established in DY3. Numerator: Targeted PPAs in DY 5 Denominator: Targeted PPAs in DY 3 Data Source: EHR; hospital admission records</td>
</tr>
<tr>
<td>Data source: urgent care implementation plan</td>
<td>Process Milestone 2 Estimated Incentive Payment: $61,667</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $97,500</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $203,500</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $61,667</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount:** (add incentive payments amounts from each milestone) $61,667

| Year 3 Estimated Milestone Bundle Amount: $61,667 | Year 4 Estimated Milestone Bundle Amount: $97,500 | Year 5 Estimated Milestone Bundle Amount: $203,500 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $419,333
**Title of Outcome Measure (Improvement Target):** IT-6.1 Percent improvement over baseline of patient satisfaction scores: (3) patient’s rating of doctor access to specialist.

**Performing Provider:** Rice Medical Center

**TPI:** 212060201

**Unique RHP Outcome ID:** 212060201.3.8

**Outcome Measure Description:**
By adding new specialists in its hospital clinic, Rice will increase its patients’ satisfaction with their and their doctors’ access to specialists. Rice will measure the satisfaction of all its patients in this domain, with the expected outcome of an increase in satisfaction as the specialty services expand.

**Process milestones:**

- DY2: Rice will engage in project planning in order to use the addition of local specialists to improve patients’ satisfaction with their access to specialty care physicians.
- DY3: Rice will establish a baseline measurement of patients’ satisfaction with their access and their PCP’s access to specialists, in order to measure improvement going forward.

**Starting Point/Baseline:**
Rice is not currently measuring patients’ satisfaction with their or their doctors’ access to specialists.

**Rationale:**
Colorado County is a rural community. It can be very difficult for patients to access specialists, often having to travel long distances. Likewise, it is difficult for patient’s primary care physicians to coordinate with specialists for consultation and referral from a rural community. Patient satisfaction will increase when patients have closer and more immediate access to specialty care for consultations and referrals, especially as this is expected to result in improved patient outcomes.

**Project Valuation:**
The valuation of each Rice project takes into account the degree to which the project accomplishes the triple aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. The value of this project is based on Rice’s belief that patient satisfaction leads to increased and earlier use of the health care delivery system, and better overall patient outcomes and quality of life. The ENT is a physician able to treat a myriad of conditions and can examine and refer patients to other providers as needed. An orthopedic specialist is likewise able to diagnose and treat a myriad of conditions, ranging from chronic
conditions to severe injuries. Obesity can cause or be related to conditions appropriate for ENT or orthopedic care (i.e. snoring/sinus conditions, joint deterioration, etc.), indicating a need for these specialties in this community where obesity is especially prevalent. This is especially important because both of these specialists are trained in medicine and surgery, which most PCPs are not. Many of the people Rice treats each year through its hospital and/or clinics will benefit from the weekly availability of these providers, especially due to the high rate of obesity and poor physical health in the County. This increased access should go far to improve patients’ satisfaction with their ability to access the right care from the right provider. For these reasons, this outcome is of high value to the community and Rice assigned value to the outcome accordingly.
### Percent Improvement over Baseline of Patient Satisfaction Scores (3) patient’s rating of doctor access to specialist.

**Rice Medical Center**

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Outcome Project(s):</th>
<th>212060201.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be established in DY3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]: Project planning.</strong></td>
<td><strong>Process Milestone 2 [P-2]: Establish a baseline.</strong></td>
<td><strong>Outcome Improvement Target 1 [IT 6.1(3)]:</strong> — Percent Improvement Over Baseline Of Patient Satisfaction Scores: Establish an increase in Rice’s patients’ ratings of their doctor access to specialist.</td>
<td><strong>Outcome Improvement Target 2 [IT 6.1(3)]:</strong> — Percent Improvement Over Baseline Of Patient Satisfaction Scores: Establish an increase in Rice’s patients’ ratings of their doctor access to specialist.</td>
</tr>
<tr>
<td><strong>Metric 1:</strong> Rice will identify the correct survey instrument, train providers on administering the survey, and begin educating patients on the hospital’s initiative to improve patient satisfaction.</td>
<td><strong>Metric 1:</strong> Using the HCAHPS standardized survey instrument, Rice will establish the average patient rating concerning their doctor access to specialists.</td>
<td><strong>Metric 1:</strong> X percent improvement in targeted patient ratings Improvement Target: TBD Data Source: Survey results</td>
<td><strong>Metric 1:</strong> X percent improvement in targeted patient ratings Improvement Target: TBD Data Source: Survey results</td>
</tr>
<tr>
<td><strong>Process Milestone 1 Estimated Incentive Payment:</strong> $102,778</td>
<td><strong>Process Milestone 2 Estimated Incentive Payment:</strong> $102,778</td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong> $154,167</td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong> $339,167</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Milestone Bundle Amount:** $102,778 **Year 3 Estimated Milestone Bundle Amount:** $102,778 **Year 4 Estimated Milestone Bundle Amount:** $154,167 **Year 5 Estimated Milestone Bundle Amount:** $339,167

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):** $698,889
**Title of Outcome Measure (Improvement Target):** IT-6.1 Percent improvement over baseline of patient satisfaction scores: (1) patients are getting timely care, appointments, and information.

**Performing Provider:** Rice Medical Center

**TPI:** 212060201

**Unique RHP Outcome ID:** 212060201.3.9

**Outcome Measure Description:**
The outcome of Expanding the East Bernard Clinic will to improve patient satisfaction scores in the domain of timeliness of appointments, care, and information. Rice will measure patient satisfaction of the clinic’s patients using the CAHPS survey.

**Starting Point/Baseline:** Rice is not currently measuring patient satisfaction for the East Bernard Clinic. The clinic treated approximately 2800 patients in 2012.

**Rationale:** According to the Planning Protocol, “Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment.” Rice intends to improve patient access and patients’ perception of their access in East Bernard, which Rice expects will result in improved health outcomes (as patients will engage in preventative care more readily if they feel they have adequate access).

**Project Valuation:** The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project is valued to reflect the importance of maintaining patient satisfaction with the provision of primary healthcare so that patients will continue to participate in the system. Like the rest of Wharton County, East Bernard suffers from a higher rate of poor physical and mental health days and preventable hospital stays than the Statewide average; access to primary care may reduce these local trends, through improving the health of the community. Rice expects the increased availability of appointments for local patients to improve patients’ willingness and ability to engage in preventative medical care. Additionally, if patients have access to more appointments, they will be better acquainted with their providers and more likely to trust/follow their recommendations, which should in turn improve their satisfaction with their care. For these reasons, Rice views this outcome as high value for the community and assigned its value accordingly.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Project(s):</th>
<th>212060201.6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be established in DY3.</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-1]: Project planning.</td>
<td>Process Milestone 2 [P-2]: Establish a baseline.</td>
</tr>
<tr>
<td>Metric 1: Determine the best instrument for measuring patient satisfaction scores, train providers in the East Bernard Clinic to administer the survey, and create system for collecting and reporting the scores.</td>
<td>Metric 1: Measure the patient satisfaction of the East Bernard Clinic’s patients with the timeliness of their appointments, care, and information (using a validated assessment tool)</td>
</tr>
<tr>
<td>Data source: documentation of project implementation plan/tracking system and provider training</td>
<td>Data Source: Survey results</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $82,222</td>
<td>Process Milestone 2 Estimated Incentive Payment: $82,222</td>
</tr>
<tr>
<td>Year 2 Estimated Milestone Bundle Amount: $82,222</td>
<td>Year 3 Estimated Milestone Bundle Amount: $82,222</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $559,111**
Spindletop Center

Pass 1
**Title of Outcome Measure (Improvement Target):** OD-6 Patient Satisfaction

IT-6.1 (1) Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information

**Unique RHP Project identification number:** 096166602.3.1

**RHP Performing Provider / TPI:** Spindletop Center / 096166602

**Outcome Measure Description:**
For demonstration years 3-5, Spindletop has selected improvement outcome measure IT-6.1 (1), percent improvement over baseline of patient satisfaction scores, patients are getting timely care, appointments, and information. The process milestone selected for demonstration year 2 to prepare for the outcomes is P-2, establish baseline rates. This will involve developing a patient satisfaction survey for the new service to be provided and establishing the satisfaction baseline in year 2.

**Rationale:**
Since the goal of this project is to provide expanded primary care for our behavioral health clients, measuring the availability and timeliness of physical health care and appointments that meet clients’ needs is important. If clients are satisfied with the service, they will be more likely to access primary care that will lead to improved physical health.

**Outcome Measure Valuation:**
Spindletop considered several factors in valuing this project including reductions in costs associated with emergency room visits and hospitalizations for diseases and illnesses. Improving the physical health of behavioral health clients should reduce the number of ED visits and the occurrences of hospitalizations.

Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.
<table>
<thead>
<tr>
<th>Project ID</th>
<th>Description</th>
<th>Related Category 1 or 2 Projects:</th>
<th>Starting Point/Baseline:</th>
</tr>
</thead>
<tbody>
<tr>
<td>096166602.3.1</td>
<td>IT-6.1(1) Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information</td>
<td></td>
<td>To be established in Year 2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 P-2:</strong> Establish baseline rates</td>
<td><strong>Outcome Improvement Target 1 IT-6-1(1):</strong> Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information</td>
<td><strong>Outcome Improvement Target 2 IT-6-1(1):</strong> Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information</td>
<td><strong>Outcome Improvement Target 3 IT-6-1(1):</strong> Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information</td>
</tr>
<tr>
<td>Data Source: Survey document; survey results</td>
<td>Data Source: Survey results</td>
<td>Data Source: Survey results</td>
<td>Data Source: Survey results</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $14,073</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $32,623</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $34,899</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $75,869</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: $14,073 | Year 3 Estimated Outcome Amount: $32,623 | Year 4 Estimated Outcome Amount: $34,899 | Year 5 Estimated Outcome Amount: $75,869 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $157,464*
Title of Outcome Measure (Improvement Target): IT-6.1 (1) Percent improvement over baseline of patient satisfaction scores-Patients getting timely healthcare information

Unique RHP outcome identification number(s): 096166602.3.2 / Pass 2
RHP Performing Provider / TPI: Spindletop Center / 096166602

Outcome Measure Description:

The process milestone selected for demonstration year 3 to prepare for the outcomes is P-1, project planning. The process milestone selected for demonstration year 3 is P-2, establish baseline rates. This will involve conducting a patient satisfaction survey for the new service to be provided and establishing the satisfaction baseline in year 3.

For demonstration years 4-5, Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores-patients getting timely healthcare information.

Rationale:

Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores, patients getting timely health information. One of the purposes of this project is for clients to have access to their healthcare information and learn skills that allow them to become more self-sufficient and have more control over their physical and behavioral health. The survey will be designed to produce comparable data on the patient's perspective on care that will allow objective and meaningful assessment of the program in meeting the needs of the clients. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

Outcome Measure Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders and emergency room visits. Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Since behavioral health clients have a high incidence of severe illnesses that shorten their life spans by 25 years compared to the general public, any programs that improve their mental and physical health should increase both the length and quality of their lives.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Develop project plan</th>
<th>Process Milestone 2 [P-2]: Establish baseline rates</th>
<th>Outcome Improvement Target 1 [IT-6.2]: Percent improvement over baseline of patient satisfaction scores-Patients getting timely healthcare information</th>
<th>Outcome Improvement Target 2 [IT-6.2]: Percent improvement over baseline of patient satisfaction scores-Patients getting timely healthcare information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Plan documentation</td>
<td>Data Source: Survey document; survey results</td>
<td>Improvement Target: TBD</td>
<td>Improvement Target: TBD</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $2,180</td>
<td>Process Milestone 2 Estimated Incentive Payment: $5,165</td>
<td>Data Source: Survey results</td>
<td>Data Source: Survey results</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $2,180</td>
<td>Year 3 Estimated Outcome Amount: $5,165</td>
<td>Year 4 Estimated Outcome Amount: $5,590</td>
<td>Year 5 Estimated Outcome Amount: $12,108</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $25,043*
St. Joseph Medical Center
Pass 1
Title of Outcome Measure (Improvement Target): IT-1.18 Follow-Up after Hospitalization for Mental Illness – NQF 0576

Unique RHP outcome identification number(s): 181706601.3.1

Outcome Measure Description:
This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Rate reported will be those patients with follow up visits within 30 days of discharge.

Tracking of recidivism of these patients to either the St. Joseph Behavioral inpatient or PHP program will indicate if the patient has maintained their treatment recommendations subsequent to discharge.

An indicator of patient compliance and treatment adherence is the “no show” rate. We will track the no show rate; along with a number of variables to determine success.

Process Milestones:
- DY2: P-1
- DY3: P-2

Outcome Improvement Targets for each year:
- DY4:
  - IT-1.18 - Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.
  - Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.
    - 25% increase in patients receiving after hospitalization follow-up care based on current discharge data for most common diagnoses
- DY 5:
  - IT-1.18 - Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.
  - Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.
    - 25% increase in patients receiving after hospitalization follow-up care based on DY4 discharge data for most common diagnoses identified above
**Rationale:**

Improvement Target 1 and Improvement Target 2 were chosen because: we initially need some time to pull together the community information and collect data from the community. Subsequent to that this is considered standard data for most providers and an industry standard to review regarding patient follow up visits and compliance.

This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Rate reported will be those patients with follow up visits within 7 and 30 days of discharge.

Tracking of recidivism of these patients to either the St. Joseph Behavioral inpatient or PHP program will indicate if the patient has maintained their treatment recommendations subsequent to discharge.

An indicator of patient compliance and treatment adherence is the “no show” rate. We will track the no show rate to determine success.

**Outcome Measure Valuation:**

Extensive analysis was performed to value this outcome measure at $1,742,432 over the four years, beginning DY2 – 5. Decrease on recidivism and the cost associated with such things as medication follow-up alone will provide enough value to the community to justify the valuation.
### Related Category 1 or 2 Projects:

<table>
<thead>
<tr>
<th>Starting Point/Baseline</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process baseline rates- Follow-Up after Hospitalization for Mental Illness- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Data Source: Project planning documentation</td>
<td>Outcome Improvement Target 1 [IT-1.18]: Follow-Up after Hospitalization for Mental Illness Improvement Target: Rate 1 and 2: 25% increase from DY 3 in patients who receive follow up care after hospitalization for Mental Illness Data Source: EHR, Claims, Medical Records</td>
<td>Outcome Improvement Target 2 [IT-1.18]: Follow-Up after Hospitalization for Mental Illness Improvement Target: Rate 1 and 2: 25% improvement from DY 4 discharge data Data Source: EHR, Claims, Medical Records</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $1,500,000</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $350,000</td>
<td>Process Milestone 3 Estimated Incentive Payment: $400,000</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $750,000</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $750,000</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $350,000</td>
<td>Year 3 Estimated Outcome Amount: $400,000</td>
<td>Year 4 Estimated Outcome Amount: $750,000</td>
<td>Year 5 Estimated Outcome Amount: $1,500,000</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $3,000,000
**Title of outcome measure (improvement target):** IT-9.2 ED appropriate utilization

**Unique RHP outcome identification number(s):** 181706601.3.2

**Performing Provider name/TPI:** St. Joseph Medical Center (SJMC)/181706601

**Outcome Measure Description:**

IT-9.2 ED appropriate utilization will measure reduced Emergency Department visits for Behavioral Health/Substance Abuse target conditions at St. Joseph Medical Center.

This measure will help to identify best practices, integrate those best practices into this setting and ensure that St. Joseph’s works collaboratively with other providers in the RHP to share data and best practices to enhance the overall service delivery and outcomes within the community.

**Process Milestones:**

- DY2: P-1
- DY3: P-2

**Outcome Improvement Target(s) for each year:**

- DY4: IT-9.2 Reduce ED visits for behavioral health or substance abuse (TBD)
- DY5: IT-9.2 Reduce ED visits for behavioral health or substance abuse (TBD)

**Rationale:**

The goal is to ensure that all clients are treated in the most appropriate manner for their co-occurring mental health and medical issues. The measure selected would allow us to track if we are accomplishing this goal while also ensuring that clinically we are using the most relevant model of care for this population.

This measure was selected (9.2) to ensure that individuals that require this type of service are assessed prior to admission for appropriateness. In the case of transfers from other facilities, the team will complete the transfer (memorandum of transfer- MOT) – thus reducing this patient load from going through the emergency room process. The MOT process (nurse-to-nurse and doctor-to-doctor) will be completed by the unit staff and transfers will be accepted based upon admissions criteria determined by the physicians. Currently, any patient with a primary diagnosis of medical illnesses is routed through the emergency room and any patient with a primary psychiatric diagnosis is routed through the behavioral health building’s intake department.

Process measure P-1 and P-2 were selected to allow for time to ensure that time was allotted to prepare and develop a plan for this program. The other areas were selected to ensure that the program works collaboratively with the other RHP providers to share best practices and enhance outcomes.

**Outcome Measure Valuation:**

Extensive analysis was performed to value this outcome measure at $1,727,432 over the four years, beginning with DY2 – DY5. Benefits to the community include the increase in available
beds in the community to which patients with dual diagnoses (behavioral and medical) can be admitted. This coordinated care in the right setting will reduce readmissions, medical complication rates and overall length of stay, saving the unnecessary burdens of treating these patients.
| Year 2 (10/1/2012 – 9/30/2013) | Milestone 1 [P-1]: Process Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
Baseline/Goal: Produce a comprehensive report documenting all points above. To continue Milestone 1 each year.  
Data Source: Project plan | Milestone 2 [P-2]: Establish baseline rates- ED visits for behavioral health and substance abuse  
Data Source: Evaluate the electronic health record for co-occurring diagnosis data  
Milestone 2 Estimated Incentive Payment: $400,000 | Outcome Improvement Target 1 [IT 9.2]: ED appropriate utilization- Reduce ED visits for behavioral health and substance abuse  
Improvement target: Reduce ED visits for behavioral health or substance abuse (TBD)  
Data source: EMR  
Outcome Improvement Target 1 Estimated Incentive Payment: $750,000 | Outcome Improvement Target 2 [IT 9.2]: ED appropriate utilization- Reduce ED visits for behavioral health and substance abuse  
Improvement target: Reduce ED visits for behavioral health or substance abuse (TBD)  
Data Source: EMR  
Milestone 5 Estimated Incentive Payment: $1,500,000 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $350,000</td>
<td>Year 3 Estimated Milestone Bundle Amount: $400,000</td>
<td>Year 4 Estimated Milestone Bundle Amount: $750,000</td>
<td>Year 5 Estimated Milestone Bundle Amount: $1,500,000</td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td></td>
<td>Year 4 Estimated Milestone Bundle Amount: $750,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
<td>Year 4 Estimated Milestone Bundle Amount: $750,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over DYs 2-5): $3,000,000*
St. Luke's Episcopal Hospital
Pass 1
Title of Outcome Measure (Improvement Target): IT-3.2 Potentially Preventable Re-Admissions – 30-day Readmission Rates (PPRs)/Congestive Heart Failure 30-day Readmission Rate

Unique RHP outcome identification number: 127300503.3.1 St. Luke’s Episcopal Hospital

Outcome Measure Description:

The goal of this project is to reduce by 30% the rate of 30-day potentially preventable re-admissions for chronic heart failure (CHF) patients according to the Hospital Compare publically reported data. Currently, St. Luke’s experiences a 24.8% re-admission rate for the CHF patients, according to publicly reported data accessed at Hospital Compare. By creating a Transitional Care Clinic for the at-risk, underserved populations, these patients will gain access to timely essential care on a consistent basis. In addition, St. Luke’s will work with the St. Luke’s Episcopal Health Charities Project Safety Net to identify primary care providers within the patient’s local community. The combination of these two services will create a partnership with the patients and provide an opportunity for the patients to discuss health and social concerns. Additionally, patients will have concerns addressed on a timely basis by a care-team provider. This, in turn, will reduce the need for more costly acute, inpatient care.

Over the course of the project, the readmission rate will be reduced by 30%.

Process Milestones:
- DY 2: P-1, P-3
- DY 3: P-2

Outcome Improvement Target for each year:
- DY 4: IT-3.2 Potentially Preventable Readmission Rates - CHF
- DY 5: IT-3.2 Potentially Preventable Readmission Rates - CHF

Rationale:

The process milestones and outcome improvement target of reducing the 30-day potentially preventable re-admission rate was selected because of its impact on the overall health-status of at-risk CHF patients. The creation of a Transitional Care Clinic will provide access to consistent care for at-risk, and underserved patient populations. In addition, St. Luke’s will utilize the St. Luke’s Episcopal Health Charities Project Safety Net Portal to identify primary care providers within the patient’s local community that can serve as an additional health resource. By improving access these patients will receive high-quality care on a consistent basis, which should lead to an improved health status of each of these patients. In addition, the patients will need fewer acute, inpatient admissions and emergency department visits, which will benefit not only the patient but the community at-large by improving efficient utilization of scarce healthcare resources and reducing the overall cost of healthcare.

The data collected through more consistent visits with the at-risk and underserved populations will also lead to identification of health trends within communities and allow for better prioritization of community-health needs. This will allow for more targeted, effective interventions to be created that will improve the overall health status of the community-at-large and reduce regional health-care expenditures.
Outcome Measure Valuation:

The project scope includes all patients with an index admission of congestive heart failure at St. Luke’s Episcopal Hospital. This is anticipated to be approximately 6,000 patients. The intervention begins with education upon admission. The care team will also provide information about the services of the Transitional Care Clinic. Prior to discharge, a follow-up appointment will be scheduled within seven days for each patient. In addition, the care team providers will identify if the patient currently has consistent primary care support. If none is identified, the team will assist the patient in finding stable primary care.

All patients identified with CHF will be supported with this intervention; however, specific-focus will be given to those most at-risk, including the underserved and uninsured.

This addresses a high-priority community need due to the incidence of heart disease. The overall community will benefit by savings achieved by reducing the unnecessary and costly use of acute hospital services.
### Performing Provider: St. Luke’s Episcopal Hospital

**Related Category 2 Projects**: 127300503.2.1

#### Starting Point/Baseline

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
| **Process Milestone 1 [P-1]**: Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan.  
   Data Source: Committee minutes, finalized plan  
   Data Source: Claims, EHR.  
   Process Milestone 3 Estimated Incentive Payment: $219,968 | **Outcome Improvement Target 1 [IT-3.2]**: Congestive Heart Failure 30 day readmission rate  
   **Data Source**: EHR  
   **Goal**: Improve over baseline XX%  
   Outcome Improvement Target 1 Estimated Incentive Payment: $643,872 | **Outcome Improvement Target 3 [IT-3.2]**: Congestive Heart Failure 30 day readmission rate  
   **Data Source**: EHR  
   **Goal**: Improve over baseline XX%  
   Outcome Improvement Target 3 Estimated Incentive Payment: $1,400,563 |
| **Process Milestone 2 [P-3]**: Develop and test data systems.  
   Data Source: Claims and related data.  
   Process Milestone 2 Estimated Incentive Payment: $196,202 | | | |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**: $2,876,774

**Year 2: Estimated Milestone Bundle Amounts**: $392,404

**Year 3: Estimated Milestone Bundle Amounts**: $439,935

**Year 4: Estimated Milestone Bundle Amounts**: $643,872

**Year 5: Estimated Milestone Bundle Amounts**: $1,400,563
Title of Outcome Measure (Improvement Target): OD-10 Quality of Life/Functional Status
Unique RHP Outcome Identification Number: 127300503.3.2 - St. Luke’s Episcopal Hospital

Outcome Measure Description:
Quality of life (QOL) is a broad multidimensional concept that usually includes subjective evaluations of the patient’s perceptions of mental and physical indicators. Quality of life is a challenging measure in that it is subjective and dependent upon the client’s perceptions of each domain. Further, the term “quality of life” has meaning for nearly everyone and every academic discipline, individuals and groups can define it differently.

Process Milestones:
- DY 2: P-1, P-3
- DY 3: P-2

Outcome Improvement Target for each year:
- DY 4: IT-10.1 Quality of Life
- DY 5: IT-10.1 Quality of Life

Rationale:
Chronically ill patients’ QOL is a major driver to both the pursuit of medical care and adherence to medical therapy. Therefore, we find QOL is a significant indicator of the success of any disease management program.

Outcome Measure Valuation:
In the St. Luke’s Episcopal Hospital program, we will use CDC HRQOL scores to measure our social and clinical interventions. Through repeated measures of CDC HRQOL we will monitor the patient’s experience. Additionally, aggregation of CDC HRQOL data will provide an assessment of efficacy.

The evaluation of CDC HRQOL combined with the readmission rate provides a balanced set of measures to assess effectiveness of our intervention.
<table>
<thead>
<tr>
<th>Related Category 2 Projects</th>
<th>127300503.2.1</th>
<th>Quality of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performing Provider: St. Luke’s Episcopal Hospital</td>
<td>127300503</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Starting Point/Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
</tr>
</tbody>
</table>
| **Process Milestone 1 [P-1]**: Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan.  
Data Source: Committee minutes, finalized plan | **Process Milestone 2 [P-2]**: Establish baselines.  
Data Source: TBD.  
Process Milestone 2 Estimated Incentive Payment: $219,968 | **Outcome Improvement Target 2** [IT-10.1]: Quality of Life  
Data Source: Assessment tool  
Goal: Improve over baseline XX%  
Outcome Improvement Target 2 Estimated Incentive Payment: $643,872 | **Outcome Improvement Target 3** [IT-10.1]: Quality of Life  
Data Source: Assessment tool  
Goal: Improve over baseline XX%  
Outcome Improvement Target 3 Estimated Incentive Payment: $1,400,563 |
| Process Milestone 1 Estimated Incentive Payment: $392,404 |
| Year 2: Estimated Milestone Bundle Amounts: $392,404 | Year 3: Estimated Milestone Bundle Amounts: $439,935 | Year 4: Estimated Milestone Bundle Amounts: $643,872 | Year 5: Estimated Milestone Bundle Amounts: $1,400,563 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $2,876,774
St. Luke's Episcopal Hospital
Pass 2
Title of Outcome Measure (Improvement Target): IT-4.1 Improvement in risk adjusted Potentially Preventable Complication rates

Unique RHP Outcome ID: 127300503.2.2 / Pass 2

Outcome Measure Description:
Potentially preventable complications of Hepatitis C include the development of cirrhosis, progressive liver failure and death. Based on estimates of prevalence within the population and the know efficacy of current therapies achieving a 60% cure rate, we plan to prevent progression to active Hepatitis C in at least 444 patients through active screening and effective intervention.

Process Milestones:
- DY2: P-1
- DY3: P-2

Outcome Improvement Target(s) for each year:
- DY3:
  - IT-4.1 Improvement in risk adjusted Potentially Preventable Complication rates
  - Baseline/Goal: 5%
- DY4:
  - IT-4.1 Improvement in risk adjusted Potentially Preventable Complication rates
  - Improve over baseline 10%
- DY5:
  - IT-4.1 Improvement in risk adjusted Potentially Preventable Complication rates
  - Improve over baseline 30%

Rationale:
Outcome improvement targets will determined in DY2.

Outcome Measure Valuation:
In Year 2 as partnerships are developed beyond current relationships, 2000 individuals will be screened. In Years 3 (3500) and 4 (5000) the volume of screening would increase incrementally with the expected volume of screening in Year 5 reaching 8000. As a result of the increased screenings, we would expect to identify additional individuals in the at-risk group. The expected outcome is projected as follows;

- Year 2 – 160
- Year 3 – 280
- Year 4 – 400
- Year 5 - 640

1. Total number of individuals identified with disease over project equals 1480. If approximately 50% of 1480 new patients will be engaged in active community based treatment, we would expect 60% cure rate equaling 444 patients. The lifetime cost of Hepatitis C in the absence of liver transplant is $100,000. With liver transplant, the cost rises to $280,000. Within 5 years of diagnosis, 15-20% of patients with chronic Hepatitis
C develop cirrhosis. Consequently, diagnosis, treatment and cure dramatically lower costs for treatment of a chronic disease. If the epidemiologic estimates are much more modest, assuming cure in only 10% of the potential, the likely cost savings will easily exceed $4.4 million (lifetime cost for one patient with Hepatitis C is $100,000, with liver transplant cost rises to $280,000).
<table>
<thead>
<tr>
<th><strong>Performing Provider:</strong> St. Luke’s Episcopal Hospital</th>
<th><strong>127300503</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Related Category 2 Projects</strong></td>
<td><strong>127300503</strong></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline</strong></td>
<td><strong>127300503</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1 [P-1]:** Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan.  
Data Source: Committee minutes, finalized plan

**Process Milestone 2 [P-2]:** Establish baselines.  
Data Source: TBD.  
Estimated Incentive Payment: $53,663

**Outcome Improvement Target 1 [IT-4.1]:** Potentially Preventable Complication rates  
Data Source: Assessment tool  
Baseline/Goal: to be determined in DY3

**Outcome Improvement Target 2 [IT-4.1]:** Potentially Preventable Complication rates  
Data Source: Assessment tool  
Goal: Improve over baseline XX%  
Estimated Incentive Payment: $174,215

**Outcome Improvement Target 3 [IT-4.1]:** Potentially Preventable Complication rates  
Data Source: Assessment tool  
Goal: Improve over baseline XX%  
Estimated Incentive Payment: $415,126
**Performing Provider:** St. Luke’s Episcopal Hospital

<table>
<thead>
<tr>
<th>Year</th>
<th>Category</th>
<th>Outcome Improvement Target 1</th>
<th>Estimated Incentive Payment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2: Estimated Milestone Bundle Amounts: $90,598</td>
<td></td>
<td></td>
<td>$53,664</td>
</tr>
<tr>
<td>Year 3: Estimated Milestone Bundle Amounts: $107,327</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4: Estimated Milestone Bundle Amounts: $174,215</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5: Estimated Milestone Bundle Amounts: $415,126</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $787,266
Texana Center

Pass 1
Title of Outcome Measure: IT-10.2 Quality of Life/Activities of Daily Living

Unique RHP outcome identification number: 081522701.3.1

Outcome Measure Description:
This Category 3 Outcome Measure, Quality of Life, OD 10, 10.2 Activities of Daily Living assesses the effectiveness of the Texana Center Category 1 Project, Option 1.12.2, to enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders) to expand the number of community based settings where behavioral health services may be delivered in underserved areas. The desired outcome of the Category 1.12.2 Project is to increase utilization of community behavioral healthcare (i.e., ABA and SLP services for autism) by adding an additional setting. Expanding the availability of behavioral health services is consistent with the Category 3 Outcome Measure, OD 10 Quality of Life, IT-10.2 Activities of Daily Living.

Process Milestones:
The following Category 3 Process Measures will define the activities undertaken by Texana Center to prepare for measuring and reporting the improvement targets in DY 4 and DY 5:
- DY 2 - P-1: Completion of project planning to prepare for reporting
- DY 2 and 3 - P-2: Establishment of a baseline for measuring and reporting progress
- DY 3 - P-3: Preparation of data systems
- DY 3 - P-4: Implementation of continuous quality improvement (CQI) processes for data and reporting (Conduct Plan, Do, Study, Act (PDSA) cycles)

Outcome Improvement Target(s) for each year:
The following Category 3 Improvement Target, IT-10.2, was selected to measure the success of Texana Center’s Category 1 Project, Option 1.12.2 during DY 4 and DY 5:
- Demonstrate improvement in quality of life/activities of daily living scores as measured by evidence-based and validated assessment tool(s), for children diagnosed with Autism (standalone measure).

Rationale:
Although much of behavioral healthcare is focused on reducing psychiatric symptoms, this intensive ABA and SLP treatment is specifically designed to improve symptoms and functions, 2 essential components of quality of life. Research indicates that approximately 50% of children that receive 1:1 intensive ABA before the age of 4 for 25-40 hours a week for at least 2 years will no longer meet the diagnostic criteria for an ASD diagnosis (Howard, et al. 2005). Recent research, including the National Standards Project, emphasizes the importance of empirically based Speech Language Pathology (SLP) intervention in addition to the primary mode of intervention of ABA. Effective quality improvement requires relentless focus on patient outcomes. Early intensive ABA treatment results in increased language and communication skills, improved social skills, achievement in pre-academic and academic areas, and decreased problem behaviors (Howard et al. 2005). Early intensive behavior intervention can be costly, exceeding $50,000 per year. This project will improve access to needed behavioral health services for low income families, 70-90% of the children will be Medicaid eligible.
Baseline data will be collected during years 2 and 3 using a variety of the below and related assessment tools. One or a combination of 2 or 3 of these tools will be utilized to demonstrate progress during years 3-5 based on baseline data collected during years 2 and 3.


- Demonstrated improvement in quality of life on the Assessment of Basic Language and Learning Skills (ABLLS), Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), and/or the Assessment of Functional Living Skills (AFLS). Progress can be measured by examining changes in the student’s scores from one administration to the next (e.g., Goin-Kochel, Myers, Hendricks, Carr, & Wiley, 2007; Sullivan & Perry, 2006). The ABLLS-R was selected because it is now commonly used by educators, school personnel, and psychologists to assess and monitor skills of children with autism who are receiving behavior therapy (e.g., Bradley-Johnson, Johnson, & Vladescu, 2008; Goin-Kochel et al., 2007; Schwartz, Bouware, McBride, & Sandall, 2001) and, according to Aman et al. (2004), has been selected as an outcome measure by the National Institute of Mental Health Research Units in Pediatric Psychopharmacology and Psychological Intervention Autism Network.

Outcome Measure Valuation:

The Category 3 Outcome Measure, Quality of Life, is valued as a subset to the valuation for the Texana Center Category 1.12.2 to enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders) to expand the number of community based settings where behavioral health services may be delivered in underserved areas. The Category 1.12.2 Project, and supporting Category 3 Outcome Measures, addresses a priority need for the population of children diagnosed with autism.

This project addresses a priority need for the autism population to receive intensive ABA services in the community. One of the goals of this project is to avert outcomes such as potentially avoidable inpatient admissions and readmissions in settings including general acute and psychiatric hospitals, state supported living centers, and self-contained special education classrooms; to promote wellness and adherence to treatment; to promote independence in the community/functional status; and to improve quality of life. The vision will be realized throughout the child's lifetime, however, the reduction in the need for self-contained special education classrooms and in some cases the elimination of the need for special education for children served in this project would be realized during the 4 year DSRIP project.

By providing ABA services to children with autism, it allows for cost avoidance. The current project proposes to serve 50 children in years 2-5, with 25-40 hours per week per child of
intensive applied behavior analysis intervention. At 6 hours per day, this will be approximately 1500 hours of treatment annually per child. In 2007, Chasson et al. results indicated that the state of Texas will save $208,500 per child across eighteen years of education with early intensive ABA. Based on the figures derived from this study, the state of Texas could save $10,425,000 across 18 years of education by providing ABA treatment to these 50 children. This savings exceeds the total listed 5-year valuation for this project. In 1998, Jacobson et al. found that cost savings following intensive ABA are estimated to be from $2,439,710 to $2,816,535 with inflation to age 55 per child served (Jacobson, Mulik, & Green, 1998). Therefore, based on the figures derived from this study, the state of Texas could save $121,985,500 through age 55 for these 50 children by providing early intensive ABA treatment.

Total Five Year Valuation: $1,094,789

Resources:
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Process planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 3 [P-3]:</strong> Establish baseline data</td>
<td><strong>Outcome Improvement Target 1 [IT-10. 2]:</strong> Demonstrate improvement in quality of life scores as measured by evidence-based and validated assessment tool(s), for children diagnosed with Autism (standalone measure)</td>
<td><strong>Outcome Improvement Target 2 [IT-10. 2]:</strong> Demonstrate improvement in quality of life scores as measured by evidence-based and validated assessment tool(s), for children diagnosed with Autism (standalone measure)</td>
</tr>
<tr>
<td>Data Source: Project Documentation</td>
<td>Data Source: Project Documentation</td>
<td>Goal: Demonstrate improved standardized test scores per child from entrance to exit, criteria TBD</td>
<td>Data Source: Standardized test scores at exit from waiver program compared to scores at entrance, testing instrument TBD (see narrative)</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: N/A. Captured in Category 1 milestones.</td>
<td>Process Milestone 3 Estimated Incentive Payment: $91,232.33</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $273,697</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $547,395</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]:</strong> Establish baseline data</td>
<td><strong>Process Milestone 4 [P-3]:</strong> Develop and test data systems.</td>
<td>Goal: Demonstrate improved standardized test scores per child from entrance to exit, criteria TBD</td>
<td>Data Source: Standardized test scores at exit from waiver program compared to scores at entrance, testing instrument TBD (see narrative)</td>
</tr>
<tr>
<td>Data Source: Project Documentation</td>
<td>Data Source: Project Documentation</td>
<td>Data Source: Standardized test scores at exit from waiver program compared to scores at entrance, testing instrument TBD (see narrative)</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $273,697</td>
</tr>
<tr>
<td><strong>Process Milestone 5 [P-4]:</strong> Conduct Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities.</td>
<td><strong>Process Milestone 5 [P-4]:</strong> Conduct Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities.</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $273,697</td>
<td></td>
</tr>
<tr>
<td>Data Source: Project Documentation</td>
<td>Data Source: Project Documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $0</td>
<td>Year 3 Estimated Outcome Amount: $273,697</td>
<td>Year 4 Estimated Outcome Amount: $273,697</td>
<td>Year 5 Estimated Outcome Amount: $547,395</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):</strong> $1,094,789</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Identifying Outcome Measure and Provider Information:

**Title of the Outcome Measure:**  IT-9.4 Other Outcome Improvement Target Unique RHP Project
**Identification Number:** 081522701.3.2
**Performing Provider Name:** Texana Center
**Texas Provider Identifier:** 081522701

**Outcome Measure Description:** OD-9 Right Care, Right Setting; IT-9.4 Other Outcome Improvement Target

**Rationale:**

Within OD – 9 Right Care, Right Setting, we have decided that IT-9.4 Other Outcome Improvement Target is the best measure to use to show true system transformation. Texana currently refers most patients to the state hospital system and has the ability to track admissions through this system. We do not have the ability to track admissions through the private sector at this time although we know the private sector also admits patients from our catchment area. Based on this, we wanted to develop a measure that would capture the true preventable admissions due to having the crisis center from both sectors. Therefore, the numerator will be based on admissions prevented due to the crisis center and the denominator will be all admissions to the crisis center. In order to determine if an admission to the crisis center prevented an inpatient admission, we will perform the same assessment the state hospital system uses to determine whether an individual meets inpatient admission criteria. The individual will then be observed for 24 hours, crisis intervention services including medications will be provided and the individual will be assessed using the same tool after 24 hours in the unit. If the individual no longer meets inpatient admission criteria, the individual will be added to the numerator as an admission that was prevented. If the individual still meets inpatient admission criteria, it will not be counted and the patient will be transferred to the state hospital system or other inpatient psychiatric facility. Our hope is to increase this percentage in each demonstration year. DY3 will be used to determine the baseline number of admissions prevented and 3% increases will be the goal for DY4 and DY5. These percentage increases are based on current admission rates at the state hospital. Since there is currently no place for individuals to go in crisis in our catchment area, we know that individuals are going into Harris county and being admitted unbeknown to us. We believe the volume of individuals that we will be seeing at the crisis center will be significantly increased from the current volume of individuals that are screened for admission simply because individuals will become aware of the crisis center and not go into Harris County seeking help. We like to refer to this as the “built it and they will come” mentality. By using the measure described above, we will be able to prove up the true impact of the crisis center in not only our community but the region.

**Outcome Measure Valuation:**

This project addresses a major need in the community—-a “place” for individuals to go other than the hospital emergency rooms and jails and to avoid inpatient stays in psychiatric hospitals. This project was valued using a medical economists’ analysis to determine average savings per acute per year care episode for individuals treated in a residential setting as opposed to a hospital. The study was completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research. Based on this analysis, the value of the program, per acute care episode is $17,504 or
$1,750,392 per 100 persons served. The study also indicates that additional cost savings may be expected. Based on this and the projected volume over three years of 1,800 persons served, the valuation for this project is $31,507,056 which is significantly more than twice the value placed on this project.

Texana Center valued this category based on the overall valuation for the project and the percentage requirements of the overall valuation for this category.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>081522701.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Estimated at 40 per month based on current screening data</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-2]</td>
<td>Process Milestone 2 [P-3]: Establish baseline rates using State Hospital Inpatient Criteria Assessment Tool and Encounter Data; Estimated baseline at this time is an average of 40 per month based on performing provider screening data. Data Source: Inpatient Admission State Hospitalization Assessment Tool and encounter data</td>
</tr>
<tr>
<td>Develop and Test Data Systems</td>
<td>Process Milestone 3 Estimated Incentive Payment: $287,906</td>
</tr>
<tr>
<td>Data Source: Inpatient Admission State Hospitalization Assessment Tool to be used on current screenings to identify any potential issues with using tool and tracking data</td>
<td>Process Milestone 3 Estimated Incentive Payment: $287,906</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $0</td>
<td></td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 [P-3]:</td>
<td></td>
</tr>
<tr>
<td>Establish baseline rates using</td>
<td></td>
</tr>
<tr>
<td>State Hospital Inpatient Criteria Assessment Tool and Encounter Data; Estimated baseline at this time is an average of 40 per month based on performing provider screening data. Data Source: Inpatient Admission State Hospitalization Assessment Tool and encounter data</td>
<td></td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>081522701.1.2</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Texana Center</td>
<td>081522701</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Estimated at 40 per month based on current screening data</td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,439,902

Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2
Title of Outcome Measure (Improvement Target): 3.IT 9.4- Other Outcome Improvement Target- Mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers)

Unique RHP outcome identification number: 081522701.3.3
Performing Provider Name/TPI: Texana Center / 081522701

Outcome Measure Description:
This Category 3 Outcome Measure, Right Care, Right Setting, assesses the effectiveness of the Texana Center Category 2 Project, Option 2.13.1, for the implementation of a crisis stabilization intervention for the dually diagnosed population (i.e., persons with intellectual and developmental disabilities (IDD) with a co-occurring serious and persistent mental illness (SPMI) and/or serious behavioral challenges). The desired outcome of the Category 2.13.1 Project is to prevent, for this dually diagnosed population, unnecessary use of services in criminal justice settings, emergency rooms, and state institutions (i.e., mental hospitals and State Supported Living Centers). Prevention of services in these more restrictive settings is consistent with the Category 3 Outcome Measure, Right Care, Right Setting.

As a solution to the cyclic pattern of long term support and acute crisis intervention for the dually diagnosed IDD/SPMI population, the Texana Center Category 2.13.1 Project proposes the development of a crisis behavioral healthcare team, expanded out-of-home respite care to respond to acute behavior crisis events, and on-going supports to avert crisis and establish stable living environments. The selection of this Outcome, Right Care, Right Setting, is consistent with community needs assessment (RHP 3: CN2), which identified insufficient access to behavioral health care services resulting in delivery of inappropriate care (e.g., emergency departments or state institutional care) and increased demand on the criminal justice system.

Process Milestones:
The following Category 3 Process Measures will define the activities undertaken by Texana Center to prepare for measuring and reporting the improvement targets in DY 4 and DY 5:
- DY 2 - P-1: Completion of project planning to prepare for reporting
- DY 2 - P-2: Establishment of a baseline for measuring and reporting progress
- DY 3 - P-3: Preparation of data systems
- DY 3 - P-4: Implementation of continuous quality improvement processes for data and reporting

Outcome Improvement Target(s) for each year:
The following Category 3 Improvement Target is selected to measure the success of Texana Center’s crisis stabilization interventions for the dually diagnosed IDD/SPMI population (Category 2 Project, Option 2.13.1) during DY 4 and DY 5:
- Decrease in admissions and readmissions to state facilities (state hospitals and State Supported Living Centers) for the dually diagnosed IDD/SPMI population

Rationale:
Currently, data for tracking individuals with IDD/SPMI seeking crisis interventions is across multiple agencies, multiple data systems and varied reporting requirements. The data is present, but not in an easily accessed and meaningful reporting format. The Category 3 process milestones will allow for planning and the development of systems for identifying, accessing,
analyzing and disseminating data that will be used to report progress for the above improvement targets in DY 4 and DY 5. Additionally, once the data sources are in place, a baseline will be determined in order to measure improvement from the project’s starting point. Consistent with the regional goal for developing a culture of ongoing transformation and innovation, a continuous quality improvement milestone is included in the Category 3 process measures.

When responding to individuals with IDD/SPMI or challenging behaviors in crisis, Texana Center, as the Local ID Authority, may assist the individual with limited emergency respite, admission to a state facility, admission to an ICF/ID facility, or admission to a State Supported Living Center. These options are further limited by resources (funding) and bed availability. When the crisis is one of pending criminal charges, Texana Center is challenged to help the individual avoid further involvement in the criminal justice system. The intent of the Category 2 Project is to provide the option of emergency behavior supports and out of home respite as ‘right care, right setting’ alternative. Consider the following reasons for Texana Center selecting these Category 3 Improvement Targets to support the crisis stabilization interventions for this targeted population:

- Decrease in admissions and readmissions to state facilities (state hospitals and State Supported Living Centers) for the dually diagnosed IDD/SPMI population
  - Current state and federal initiatives, including community living options supported by the 1999 Olmstead decision, are based on evidence that patient-centered care in the most cost-effective manner is in non-institutional settings.

**Outcome Measure Valuation:**

The Category 3 Outcome Measure, *Right Care, Right Setting*, is valued as a subset to the valuation for the Texana Center Category 2.13.1 Project for the implementation of a crisis stabilization intervention for the dually diagnosed population (i.e., persons with intellectual and developmental disabilities (IDD) with a co-occurring serious and persistent mental illness (SPMI) and/or serious behavioral challenges). The Category 2.13.1 Project, and supporting Category 3 Outcome Measures, addresses a priority need for the IDD/SPMI population to receive the right care (intensive crisis stabilization services) in the right setting (their home and community). By doing so, it also allows for cost avoidance, supporting individuals in the community at a lesser cost than institutional care in state hospitals and State Supported Living Centers, and avoiding costs in the criminal justice system and emergency rooms.

Category 2.13.1 Project, and supporting Category 3 Outcome Measures, was valued based on two studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research: “Valuing the Program to Create an Assertive Community Treatment (ACT) Team for People with Intellectual and Developmental Disabilities (IDD)” and “Valuing the Crisis Respite for Children Program”. These studies were completed through a contract with Center for Health Care Services, and were based on cost-utility analysis measures and quality-adjusted life-years analysis.

For DY 2, the processes in Category 3 will be completed concurrently with those in Category 2, and the value for these activities is in Category 2 only. For DY 3, the processes in Category 3 were considered to be 10% of the value of the Category 2.13.1 Project. For DY 4, the Improvement Targets in Category 3 were considered to be 10% of the value of Category 2.13.1 Project. For DY 5, the Improvement Targets in Category 3 were considered to be 20% of the value of Category 2.13.1

**Total Five Year Valuation:** $670,170
<table>
<thead>
<tr>
<th>Year</th>
<th>Process Milestone 1 [P-1]: Process planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Project Documentation</th>
<th>Process Milestone 2 [P-2]: Establish baseline data. Data Source: Project Documentation</th>
<th>Process Milestone 3 [P-3]: Develop and test data systems. Data Source: Project Documentation</th>
<th>Process Milestone 4 [P-4]: Conduct Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Project Documentation</th>
<th>Outcome Improvement Target 1 [IT-9.4]: Decrease by 10% in mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions. Numerator: The number of individuals receiving project interventions who had a potentially preventable admission/readmission to a State Supported Living Center within the measurement period. Denominator: The number of individuals receiving project interventions. Data Source: TBD</th>
<th>Outcome Improvement Target 6 [IT-9.4]: Decrease by 20% in mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions. Numerator: The number of individuals receiving project interventions who had a potentially preventable admission/readmission to a State Supported Living Center within the measurement period. Denominator: The number of individuals receiving project interventions. Data Source: TBD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 3 Estimated Outcome Amount: $167,543</td>
<td>Year 4 Estimated Outcome Amount: $167,543</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $167,543</td>
<td></td>
<td>Outcome Improvement Target 6 Estimated Incentive Payment: $335,085</td>
<td></td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td>Year 4 Estimated Outcome Amount: $167,543</td>
<td>Year 5 Estimated Outcome Amount: $335,085</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $670,170
Texana Center
Pass 2
Title of Outcome Measure (Improvement Target) IT-11.1 Improvement in clinical indicator in identified disparity group.

Unique RHP Outcome ID: 081522701.3.4 / Pass 2

Performing Provider / TPI: Texana Center / 081522701

Outcome Measure Description:

This Category 3 Outcome Measure, Potentially Preventable Admissions, OD-11, IT-11.1 assesses the effectiveness of the Texana Center Category 1 Project, Option 1.9.2, to establish or expand initiatives to increase the availability of targeted specialty care providers for infants and toddlers 0-3 years old who exhibit mild developmental delays or have a recognized risk factor that puts them at risk of developmental delay. The desired outcome of the Category 1.9.2 project is to minimize the impact of established risk factors on developmental progress and/or to enable children with developmental delays achieve a functional status at, or near, age appropriate levels, decreasing or eliminating potential eligibility for IDEA Part B special education services. Expanding access to specialty care (OT, PT, ST, behavior analysis/therapy) is consistent with the Category 3 Outcome Measure, Potentially Preventable Admission.

The following Category 3 Process Measures will define the activities undertaken by Texana Center to prepare for measuring and reporting the improvement targets in DY 3,4, and 5:

- DY 2 - P-1: Completion of project planning to prepare for reporting
- DY 2 and 3 - P-2: Establishment of a baseline for measuring and reporting progress
- DY 3 - P-3: Preparation of data systems
- DY 3 - P-4: Implementation of continuous quality improvement (CQI) processes for data and reporting (Conduct Plan, Do, Study, Act (PDSA) cycles)

The following Category 3 Improvement Target, IT-11.1, was selected to measure the success of Texana Center’s Category 1 Project, Option 1.9.2 during DY 4 and 5.

- Demonstrate developmental functioning at, or approaching, age expectations as evidenced by scores on a standardized, evidence-based and validated assessment tool.

Rationale:

In 2010–11, children with delays or disabilities who received (therapeutic) services...showed greater than expected developmental progress. Many children exited the program functioning within age expectations, and almost all made progress. Comparison of entry and exit scores will evaluate the effectiveness of therapeutic interventions for each individual child.

School districts administer standardized tests to determine eligibility for special education services for children not having other eligibility determinations. Examination of exit scores will

---

1 Early Childhood Outcomes Center, July 2012
2 It's a New Idea, the manual for parents and students about special education services in Texas. The ARC of Texas; Advocacy, Incorporated. 2007.
provide a reliable indicator of potential eligibility for special education services and measure progress toward the project goal of increasing school readiness and decreasing the need for special education services at age 3.

Data collected in DY 2 and 3 on entry and exit test scores will establish a baseline on which to base improvement targets to be implemented in DY 4.

- This project proposes to use the Battelle Developmental Inventory 2nd Edition (BDI-2) to establish eligibility for enrollment and an individual baseline score on each child on entry into services. The developmental test will be administered a second time prior to exiting services. The BDI-2 provides a measure of progress during the preschool years and has been designed to help assess the effects of various intervention strategies for individual children and for groups of children.3
- Data collected will be categorized using criteria established by the Early Childhood Outcomes Center to measure progress toward established goals:
  - Maintained typical development
  - Achieved typical development
  - Made sufficient progress to move closer to typical development but did not achieve it
  - Made progress but did not move closer to typical development
  - Did not make progress4

**Outcome Measure Valuation:**

The Category 3 Outcome Measure, Improvement in clinical indicator in identified disparity group, is valued as a subset to the valuation for the Texana Center Category 1.9.2 to expand access to specialty care (OT, PT, ST) to infants and toddlers. The Category 1.9.2 Project, and supporting Category 3 Outcome Measures, address a priority need for the population of children with mild to moderate developmental delay or with established risk factors for delay.

One of the goals of this project is to avert outcomes such as potentially avoidable special education services and to promote independence in the community. The vision will be realized throughout the child's lifetime, however, the reduction in the need for special education for children served in this project would be realized during the 4 year DSRIP project.

---

4 Early Childhood Outcomes Center
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Process planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 3</strong> [P-3]: Establish baseline data</td>
<td><strong>Outcome Improvement Target 1</strong> [IT-11.1] Improvement in clinical indicators in identified disparity group.</td>
<td><strong>Outcome Improvement Target 2</strong> [IT-11.1] Improvement in clinical indicators in identified disparity group.</td>
</tr>
<tr>
<td>Data Source: Project Documentation</td>
<td>Data Source: Project Documentation</td>
<td>Improvement Target 75% of children exiting the waiver program will demonstrate &lt;15% developmental delay.</td>
<td>Improvement Target 75% of children exiting the waiver program will demonstrate &lt;15% developmental delay.</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: N/A. Captured in Category 1 milestones.</td>
<td>Process Milestone 3 Estimated Incentive Payment: $38,482</td>
<td>Data Source: Standardized test results on exit from waiver program</td>
<td>Data Source: Standardized test results on exit from waiver program</td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong> [P-3]: Establish baseline data</td>
<td><strong>Process Milestone 4</strong> [P-3]: Develop and test data systems.</td>
<td><strong>Numerator</strong>: number of children discharging from waiver program with &lt; 15% delay</td>
<td><strong>Numerator</strong>: number of children discharging from waiver program with &lt; 15% delay</td>
</tr>
<tr>
<td>Data Source: Project Documentation</td>
<td>Data Source: Project Documentation</td>
<td><strong>Denominator</strong>: number of children discharging from the waiver program</td>
<td><strong>Denominator</strong>: number of children discharging from the waiver program</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: N/A. Captured in Category 1 milestones.</td>
<td>Process Milestone 4 Estimated Incentive Payment: $38,482</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $124,929</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $270,624</td>
</tr>
<tr>
<td><strong>Process Milestone 5</strong> [P-4]: Conduct Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities.</td>
<td><strong>Process Milestone 5</strong> [P-4]: Conduct Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities.</td>
<td><strong>Outcome Improvement Target 1</strong> Estimated Incentive Payment: $124,929</td>
<td><strong>Outcome Improvement Target 2</strong> Estimated Incentive Payment: $270,624</td>
</tr>
<tr>
<td>Data Source: Project Documentation</td>
<td>Data Source: Project Documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 5 Estimated Incentive Payment: $38,482</td>
<td>Process Milestone 5 Estimated Incentive Payment: $38,482</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $0</td>
<td>Year 3 Estimated Outcome Amount: $115,447</td>
<td>Year 4 Estimated Outcome Amount: $124,929</td>
<td>Year 5 Estimated Outcome Amount: $270,624</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add outcome amounts over DYs 2-5): $511,000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Texana Center
Pass 3
**Title of Outcome Measure:** IT-10.2 Quality of Life/ Activities of Daily Living

**Unique RHP outcome identification number:** 081522701.3.5

**Outcome Measure Description:**
This Category 3 Outcome Measure, *Quality of Life, OD 10, IT-10.2* assesses the effectiveness of the Texana Center Category 1 Project, Option 1.12.2, to enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders) to expand the number of community based settings where behavioral health services may be delivered in underserved areas. The desired outcome of the Category 1.12.2 Project is to increase utilization of community behavioral healthcare (i.e., ABA and SLP services for autism) by adding one additional setting (a third setting to the original setting and Waiver pass 1 proposed setting). Expanding the availability of behavioral health services is consistent with the Category 3 Outcome Measure, OD 10 *Quality of Life, IT-10.2 Activities of Daily Living.*

**Process Milestones:**
The following Category 3 Process Measures will define the activities undertaken by Texana Center to prepare for measuring and reporting the improvement targets in DY 4 and DY 5:
- DY 2 and DY 3 - P-1: Completion of project planning to prepare for reporting
- DY 3 and 4 - P-2: Establishment of a baseline for measuring and reporting progress
- DY 3 and 4 - P-3: Preparation of data systems
- DY 3 - P-4: Implementation of continuous quality improvement (CQI) processes for data and reporting (Conduct Plan, Do, Study, Act (PDSA) cycles)

**Outcome Improvement Target(s) for each year:**
The following Category 3 Improvement Target, IT-10.2, was selected to measure the success of Texana Center’s Category 1 Project, Option 1.12.2 during DY 4 and DY 5:
- Demonstrate improvement in quality of life/activities of daily living scores as measured by evidence-based and validated assessment tool(s), for children diagnosed with Autism (standalone measure).

**Rationale:**
Although much of behavioral healthcare is focused on reducing psychiatric symptoms, this intensive ABA and SLP treatment is specifically designed to improve symptoms and functions, 2 essential components of quality of life. Research indicates that approximately 50% of children that receive 1:1 intensive ABA before the age of 4 for 25-40 hours a week for at least 2 years will no longer meet the diagnostic criteria for an ASD diagnosis (Howard, et al. 2005). Recent research, including the National Standards Project, emphasizes the importance of empirically based Speech Language Pathology (SLP) intervention in addition to the primary mode of intervention of ABA. Effective quality improvement requires relentless focus on patient outcomes. Early intensive ABA treatment results in increased language and communication skills, improved social skills, achievement in pre-academic and academic areas, and decreased problem behaviors (Howard et al. 2005). Early intensive behavior intervention can be costly, exceeding $50,000 per year per child. This project will improve access to needed behavioral health services for low income families, 70-90% of the children will be Medicaid eligible.
Baseline data will be collected during years 2 and 3 using a variety of the below and related assessment tools. One or a combination of 2 or 3 of these tools will be utilized to demonstrate progress during years 4-5 based on baseline data collected during years 3 and 4.


- Demonstrated improvement in quality of life on the Assessment of Basic Language and Learning Skills (ABLLS), Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), and/or the Assessment of Functional Living Skills (AFLS). Progress can be measured by examining changes in the student’s scores from one administration to the next (e.g., Goin-Kochel, Myers, Hendricks, Carr, & Wiley, 2007; Sullivan & Perry, 2006). The ABLLS-R was selected because it is now commonly used by educators, school personnel, and psychologists to assess and monitor skills of children with autism who are receiving behavior therapy (e.g., Bradley-Johnson, Johnson, &Vladescu, 2008; Goin-Kochel et al., 2007; Schwartz, Boulware, McBride, &Sandall, 2001) and, according to Aman et al. (2004), has been selected as an outcome measure by the National Institute of Mental Health Research Units in Pediatric Psychopharmacology and Psychological Intervention Autism Network.

**Outcome Measure Valuation:**

The Category 3 Outcome Measure, *Quality of Life*, is valued as a subset to the valuation for the Texana Center Category 1.12.2 to enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders) to expand the number of community based settings where behavioral health services may be delivered in underserved areas. The Category 1.12.2 Project, and supporting Category 3 Outcome Measures, addresses a priority need for the population of children diagnosed with autism.

This project addresses a priority need for the autism population to receive intensive ABA services in the community. One of the goals of this project is to avert outcomes such as potentially avoidable inpatient admissions and readmissions in settings including general acute and psychiatric hospitals, state supported living centers, and self-contained special education classrooms; to promote wellness and adherence to treatment; to promote independence in the community/functional status; and to improve quality of life. The vision will be realized throughout the child's lifetime, however, the reduction in the need for self-contained special education classrooms and in some cases the elimination of the need for special education for children served in this project would be realized during the 4 year DSRIP project.

By providing ABA services to children with autism, it allows for cost avoidance. The current project proposes to serve 26 children in years 3-5, with 25-40 hours per week per child of
intensive applied behavior analysis intervention. At 6 hours per day this will be approximately 1,500 hours of treatment annually per child. In 2007, results of a study by Chasson et al. indicated that the state of Texas will save $208,500 per child across eighteen years of education with early intensive ABA. Based on the figures derived from this study, the state of Texas could save $5,421,000 across 18 years of education by providing ABA treatment to these 26 children. This savings exceeds the total listed five year valuation for this project. In 1998, Jacobson et al. found that cost savings following intensive ABA are estimated to be from $2,439,710 to $2,816,535 with inflation to age 55 per child served (Jacobson, Mulik, & Green, 1998). Therefore, based on the figures derived from this study, the state of Texas could save $63,432,460 through age 55 for these 20 children by providing early intensive ABA treatment.

**Total Five Year Valuation: $541,379**

**Resources:**


<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Project Documentation</td>
<td>Process Improvement Milestone 1 Estimated Incentive Payment: N/A. Captured in Category 1 milestones.</td>
<td>Process Improvement Milestone 4 Estimated Incentive Payment: $40,483</td>
<td>Process Improvement Milestone 5 Estimated Incentive Payment: $40,483</td>
</tr>
</tbody>
</table>

**Outcome Improvement Target 1** [IT-10.2]: Demonstrate improvement in quality of life scores as measured by evidence-based and validated assessment tool(s), for children diagnosed with Autism (standalone measure)

Goal: Demonstrate improved standardized test score per child from entrance to exit, criteria TBD.

Data Source: Standardized test scores at exit from waiver program compared to scores at entrance, testing instrument TBD (see narrative).

Outcome Improvement Target 1 Estimated Incentive Payment: $132,716

**Outcome Improvement Target 2** [IT-10.2]: Demonstrate improved standardized test score per child from entrance to exit, criteria TBD.

Goal: Demonstrate improved standardized test score per child from entrance to exit, criteria TBD.

Data Source: Standardized test scores at exit from waiver program compared to scores at entrance, testing instrument TBD (see narrative).

Outcome Improvement Target 2 Estimated Incentive Payment: $287,215

<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount: $0</th>
<th>Year 3 Estimated Outcome Amount: $121,448</th>
<th>Year 4 Estimated Outcome Amount: $132,716</th>
<th>Year 5 Estimated Outcome Amount: $287,215</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $541,379
Texas Children's Hospital
Pass 1
**Title of Outcome Measure (Improvement Target):** OD-5: Cost of Care

**Unique RHP outcome identification number:** 139135109.3.1/Texas Children’s Hospital

**Outcome Measure Description:**

OD-5: Cost of Care  
IT-5.1 Improved cost savings Cost Effectiveness Analysis

**Process milestone:**

- DY 2 P-1; P-3  
- DY 3 P-4; P-5

**Outcome Improvement Targets for each year:**

- DY 4 IT-5.1;  
- DY 5 IT-5.1

**Rationale:**

Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

“The central purpose of cost-effectiveness analysis (CEA) is to compare the costs and the values of different health care interventions in creating better health and longer life. Many new medical devices, procedures, diagnostic tests, and prescription drugs are expensive; cost-effectiveness analysis can help to evaluate whether the improvement in health care outcomes justifies the expenditures relative to other choices.” (Focus on Cost-Effectiveness Analysis at AHRQ: Fact Sheet. August 2001. Agency for Healthcare Research and Quality, Rockville, MD. [http://www.ahrq.gov/research/findings/factsheets/costeff.html](http://www.ahrq.gov/research/findings/factsheets/costeff.html))

Cost effectiveness studies empower policy makers, hospital administrators, care providers and patients in prioritizing where finite health care dollars should be spent and what evidence-based protocols, medicines, technology and equipment should be combined in response to a population’s most compelling health need. In our project, this population is chronically ill children.

We hope to utilize the Center for Clinic Effectiveness at Baylor College of Medicine and Texas Children’s Hospital in coordinating many of our quality studies for the Waiver. Specifically, the Center is developing “score cards” of various chronic disease care models to improve our
patient-centered care resources. The goal is to establish evidence-based, structured approaches to various clinical procedures while simultaneously reducing variation in clinical practice and improve clinical and health outcomes.

**Outcome Measure Valuation:**
All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.\(^3\)


<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>139135109.1.1</th>
<th>Cost of Care</th>
<th>139135109</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td></td>
<td><strong>TBD in DY 3</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount) $31,599.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]: Test Data System</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $31,599.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic on a neurological clinic process, procedure, or test to improve efficiencies and subsequently costs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Advanced Quality Improvement (AQI) projects, Epic, Data Warehouse, physician and clinical time studies or time cards, facility costs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $36,627.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 4 [P-5]:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Reports and participation in learning collaboratives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 4 Estimated Incentive Payment: $36,627.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1 [IT-5.1] Improved cost savings:</strong> Demonstrate cost savings in care delivery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement Target: Cost Effectiveness of Neurological surgical procedures as determined by PDSA in DY 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $117,549</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement Target: Cost Effectiveness of Neurological surgical procedures as determined by PDSA in DY 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $281,095.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement Target: Cost Effectiveness of Neurological surgical procedures as determined by PDSA in DY 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $281,095.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects::</td>
<td>139135109.1.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 2 Estimated Outcome Amount: ($63,198.50)</td>
<td>Year 3 Estimated Outcome Amount: ($73,255)</td>
<td>Year 4 Estimated Outcome Amount: ($117,549)</td>
<td>Year 5 Estimated Outcome Amount: ($281,095.50)</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $535,098*
**Title of Outcome Measure (Improvement Target):** OD-5: Cost of Care

**Unique RHP outcome identification number:** 139135109.3.2/Texas Children’s Hospital

**Outcome Measure Description:**
- OD-5: Cost of Care
- IT-5.2 Per Episode of Care

**Process milestone:**
- DY 2 P-1; P-3
- DY 3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT-5.2;
- DY 5 IT-5.2

**Rationale:**
Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline costs, whether high or low, will dictate an appropriate improvement target goal.

We agree with the TX HHSC DSRIP project’s goals of this waiver specific to cost of care. Our project will strive to develop better and more robust cost-of-care measures to help those who receive care, provide care and pay for care understand how pediatric providers, especially, pediatric subspecialists, use resources and compare these costs to local, regional or national benchmarks when available.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Outcome Measure Valuation:**
All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We

---

used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.\textsuperscript{2} The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.\textsuperscript{3}

<table>
<thead>
<tr>
<th>139135109.3.2</th>
<th><strong>IT- 5.2</strong></th>
<th>Cost of Care</th>
<th>139135109</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Texas Children’s Hospital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 1 or 2 Projects:</strong></td>
<td></td>
<td></td>
<td><strong>139135109.1.1</strong></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td></td>
<td><strong>TBD in DY 3</strong></td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td>Data Source: Advanced Quality Improvement (AQI) projects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount: $31,599)</td>
<td>Process Milestone 3 Estimated Incentive Payment: $36,627</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]: Test Data System</strong></td>
<td><strong>Process Milestone 4 [P-5]:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td>Data Source: Reports and participation in learning collaboratives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $31,599</td>
<td>Process Milestone 4 Estimated Incentive Payment: $36,627</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $63,198</td>
<td>Year 3 Estimated Outcome Amount: $73,254</td>
<td>Year 4 Estimated Outcome Amount: $117,549</td>
<td>Year 5 Estimated Outcome Amount: $281,095.50</td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 2 [IT-5.2]</strong></td>
<td>Per episode cost of care Improvement Target: Determine cost of episode of care for high volume or high complexity service (e.g. Epilepsy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Numerator: total cost for episode of care</td>
<td>b. Denominator: total number of episodes in one month/year</td>
<td>c. Data Source: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system)</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $117,549</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 2 [IT-5.2]</strong></td>
<td>Per episode cost of care Improvement Target: Determine cost of episode of care for high volume or high complexity surgical service TBD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Numerator: total cost for episode of care</td>
<td>b. Denominator: total number of episodes in one month/year</td>
<td>c. Data Source: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system)</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $281,095.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add outcome amounts over DYs 2-5): $535,096.50</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.3/Texas Children’s Hospital

Outcome Measure Description:
OD-5: Cost of Care
IT-5.3 Length of Stay

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.3;
DY 5 IT-5.3

Rationale:
Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

We have specifically identified reduction in Length of Stay as one of our quality outcomes as this measure has the highest resource consumption for a patient (barring any complications due to comorbidities or severity of illness). We hope to demonstrate that a reduction in length of stay allows for a better use of existing resources and hospital capacity, thus enabling us to serve more patients in less time currently required. Ultimately, this not only improves costs but also patient satisfaction in the care provided. Because we are caring for children, this is of utmost importance – to not keep the child away from his or her home for any unnecessary length of time due to inefficiencies in care delivery and coordination of discharge.

Outcome Measure Valuation:
All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that

QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.

---

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>139135109.1.1</th>
<th>Cost of Care</th>
<th>139135109</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1 [P-1] Project Planning** – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- Data Source: EHR/Business Intelligence

**Process Milestone 2 [P-3]: Test Data System**
- Data Source: Enterprise Data Warehouse reports

**Process Milestone 3 [P-4]** Conduct PDSA by subspecialty clinic to determine the subpopulation of neurological patients with the greatest opportunity for LOS reduction to establish a baseline
- Data Source: Advanced Quality Improvement (AQI) projects, Press Ganey Survey, Epic and Enterprise Data Warehouse
- Goal: Establish ALOS and related patient satisfaction baseline

**Outcome Improvement Target 3 [IT-5.3] Length of Stay**
- Improvement Target: Using identified subset population in from process milestone 3 attempt to reduce or maintain ALOS for admissions compared to baseline
- Data Source: EPIC Medical Record, Enterprise Data Warehouse
- Estimated Incentive Payment: $117,549

**Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders
- Data Source: Reports and participation in learning collaboratives

**Outcome Improvement Target 3 [IT-5.3] Length of Stay**
- Improvement Target: Using identified subset population in from process milestone 3 attempt to reduce or maintain ALOS for admissions compared to baseline
- Data Source: EPIC Medical Record, Enterprise Data Warehouse
- Estimated Incentive Payment: $281,096
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>139135109.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $63,199</td>
<td>Year 3 Estimated Outcome Amount: $73,255</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $535,099*
Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.4/Texas Children’s Hospital

Outcome Measure Description:
OD 5 - Cost of Care
   IT-5.1 Improved cost savings: Cost Effectiveness Analysis

Process milestone:
   DY 2 P-1; P-3
   DY 3 P-4; P-5

Outcome Improvement Targets for each year:
   DY 4 IT-5.1;
   DY 5 IT-5.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline costs, whether high or low, will dictate an appropriate improvement target goal.

“The central purpose of cost-effectiveness analysis (CEA) is to compare the costs and the values of different health care interventions in creating better health and longer life. Many new medical devices, procedures, diagnostic tests, and prescription drugs are expensive; cost-effectiveness analysis can help to evaluate whether the improvement in health care outcomes justifies the expenditures relative to other choices.” (Focus on Cost-Effectiveness Analysis at AHRQ: Fact Sheet. August 2001. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/findings/factsheets/costeff.html)

Cost effectiveness studies empower policy makers, hospital administrators, care providers and patients in prioritizing where finite health care dollars should be spent and what evidence-based protocols, medicines, technology and equipment should be combined in response to a population’s most compelling health need. In our project, this population is chronically ill children.

We hope to utilize the Center for Clinic Effectiveness at Baylor College of Medicine and Texas Children’s Hospital in coordinating many of our quality studies for the Waiver. Specifically, the Center is developing “score cards” of various chronic disease care models to improve our patient-centered care resources. The goal is to establish evidence-based, structured approaches to
various clinical procedures while simultaneously reducing variation in clinical practice and improve clinical and health outcomes.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.² The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.³

---


| Related Category 1 or 2 Projects: | 139135109.1.2 |
| Starting Point/Baseline: | TBD in DY 3 |

| Year 2 | Year 3 | Year 4 | Year 5 |

**Process Milestone 1 [P-1] Project Planning** – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- Data Source: EHR/Business Intelligence

Process Milestone 1 Estimated Incentive Payment *(maximum amount)*: $19,364.75

**Process Milestone 2 [P-3]: Test Data System**

- Data Source: Enterprise Data Warehouse reports

Process Milestone 2 Estimated Incentive Payment: $19,364.75

- **Process Milestone 3 [P-4]: Conduct PDSA by subspecialty clinic on a hematology/oncology process, procedure or test to improve efficiencies and subsequently costs.**
  - Data Source: Advanced Quality Improvement (AQI) projects, Epic, Data Warehouse, physician and clinical time studies or time cards, facility costs.
  - Process Milestone 3 Estimated Incentive Payment: $22,446.25

- **Process Milestone 4 [P-5]:**
  - Disseminate findings, including lessons learned and best practices, to stakeholders
  - Data Source: Reports and participation in learning collaboratives
  - Process Milestone 4 Estimated Incentive Payment: $22,446.25

**Outcome Improvement Target 1 [IT-5.1]: Improved cost savings:**

- Demonstrate cost savings in care delivery
- Improvement Target: Cost Effectiveness of Neurological surgical procedures as determined by PDSA in DY 3
- Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)

Outcome Improvement Target 1 Estimated Incentive Payment: $72,037.25

- **Outcome Improvement Target 1 [IT-5.1]: Improved cost savings:**
  - Demonstrate cost savings in care delivery
  - Improvement Target: Cost Effectiveness of Neurological surgical procedures as determined by PDSA in DY 3
  - Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)

Outcome Improvement Target 1 Estimated Incentive Payment: $172,263.00

Region 3
### Cost of Care

**Texas Children’s Hospital**

**Related Category 1 or 2 Projects:**

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>TBD in DY 3</th>
</tr>
</thead>
</table>

#### Year 2

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $38,729.50</td>
<td>Year 3 Estimated Outcome Amount: $44,892.50</td>
<td>Year 4 Estimated Outcome Amount: $72,037.25</td>
<td>Year 5 Estimated Outcome Amount: $172,263.00</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $327,922.25*
Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.5/Texas Children’s Hospital

Outcome Measure Description: Cost of Care
   IT-5.2 Per Episode of Care:

Process milestone:
   DY 2 P-1; P-3
   DY3 P-4; P-5

Outcome Improvement Targets for each year:
   DY 4 IT-5.2;
   DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline costs, whether high or low, will dictate an appropriate improvement target goal.

We agree with the TX HHSC DSRIP project’s goals of this waiver specific to cost of care. Our project will strive to develop better and more robust cost-of-care measures to help those who receive care, provide care and pay for care understand how pediatric providers, especially, pediatric subspecialists, use resources and compare these costs to local, regional or national benchmarks when available.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is a only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. 1 Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year

(“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.\footnote{Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." \textit{Regulation}. 27.4 (2004): 60-63.}
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects</th>
<th>139135109.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>TBD in DY 3</strong></td>
</tr>
<tr>
<td>Year 2</td>
<td>Year 3</td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-1]: Project Planning</strong></td>
<td></td>
</tr>
<tr>
<td>– Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $19,364.75</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]: Test Data System</strong></td>
<td></td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $19,364.75</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 3 [P-4]: Conduct PDSA by subspecialty clinic</strong></td>
<td></td>
</tr>
<tr>
<td>Data Source: Advanced Quality Improvement (AQI) projects</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $22,446.25</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 4 [P-5]:</strong></td>
<td></td>
</tr>
<tr>
<td>Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
</tr>
<tr>
<td>Data Source: Reports and participation in learning collaboratives</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 4 Estimated Incentive Payment: $22,446.25</td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 2 [IT-5.2]:</strong></td>
<td></td>
</tr>
<tr>
<td>Per episode cost of care Improvement Target: Determine cost of episode of care for high volume or high complexity service TBD based on AQI project</td>
<td></td>
</tr>
<tr>
<td>a. Numerator: total cost for episode of care</td>
<td></td>
</tr>
<tr>
<td>b. Denominator: total number of episodes in one month/year</td>
<td></td>
</tr>
<tr>
<td>Data Source: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system)</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $72,037.25</td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong></td>
<td></td>
</tr>
<tr>
<td>$172,263.00</td>
<td></td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $38,729.50 |
| Year 3 Estimated Outcome Amount: $44,892.50 |
| Year 4 Estimated Outcome Amount: $72,037.25 |
| Year 5 Estimated Outcome Amount: $172,263.00 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $327,922.25
**Title of Outcome Measure (Improvement Target):** OD-5: Cost of Care

**Unique RHP outcome identification number:** 139135109.3.6/Texas Children’s Hospital

**Outcome Measure Description:** Cost of Care

**IT-5.3 Length of Stay**

**Process milestone:**
- DY 2 P-1; P-3
- DY 3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT-5.3;
- DY 5 IT-5.3

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We have specifically identified reduction in Length of Stay as one of our quality outcomes as this measure has the highest resource consumption for a patient (barring any complications due to comorbidities or severity of illness). We hope to demonstrate that a reduction in length of stay allows for a better use of existing resources and hospital capacity, thus enabling us to serve more patients in less time currently required. Ultimately, this not only improves costs but also patient satisfaction in the care provided. Because we are caring for children, this is of utmost importance – to not keep the child away from his or her home for any unnecessary length of time due to inefficiencies in care delivery and coordination of discharge.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver

---


and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>139135109.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-1] Project Planning</strong> – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 2 [P-3]: Test Data System</strong></td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td>Process Milestone 3 [P-4]: Conduct PDSA by subspecialty clinic to determine the subpopulation of hematology/oncology patients with the greatest opportunity for LOS reduction to establish a baseline&lt;br&gt;Data Source: Advanced Quality Improvement (AQI) projects, Press Ganey Survey, Epic and Enterprise Data Warehouse&lt;br&gt;Goal: Establish ALOS and related patient satisfaction baseline</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (<em>maximum amount</em>): $19,364.75</td>
<td>Process Milestone 3 Estimated Incentive Payment: $22,446.25</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $19,364.75</td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>139135109.1.2</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>TBD in DY 3</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):</td>
<td>$38,729.50</td>
<td>Year 3 Estimated Outcome Amount:</td>
<td>$44,892.50</td>
<td>Year 4 Estimated Outcome Amount:</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $327,922.25*
**Title of Outcome Measure (Improvement Target):** OD-5: Cost of Care

**Unique RHP outcome identification number:** 139135109.3.7/Texas Children’s Hospital

**Outcome Measure Description:**
OD-5: Cost of Care
IT-5.1 Improved cost savings Cost Effectiveness Analysis

**Process milestone:**
- DY 2 P-1; P-3
- DY3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT-5.1;
- DY 5 IT-5.1

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline costs, whether high or low, will dictate an appropriate improvement target goal.

“The central purpose of cost-effectiveness analysis (CEA) is to compare the costs and the values of different health care interventions in creating better health and longer life. Many new medical devices, procedures, diagnostic tests, and prescription drugs are expensive; cost-effectiveness analysis can help to evaluate whether the improvement in health care outcomes justifies the expenditures relative to other choices.” (Focus on Cost-Effectiveness Analysis at AHRQ: Fact Sheet. August 2001. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/findings/factsheets/costeff.html)

Cost effectiveness studies empower policy makers, hospital administrators, care providers and patients in prioritizing where finite health care dollars should be spent and what evidence-based protocols, medicines, technology and equipment should be combined in response to a population’s most compelling health need. In our project, this population is chronically ill children.

We hope to utlize the Center for Clinic Effectiveness at Baylor College of Medicine and Texas Children’s Hospital in coordinating many of our quality studies for the Waiver. Specifically, the Center is developing “score cards” of various chronic disease care models to improve our patient-centered care resources. The goal is to establish evidence-based, structured approaches to
various clinical procedures while simultaneously reducing variation in clinical practice and improve clinical and health outcomes.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.² The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---


<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td>Data Source: Advanced Quality Improvement (Aqi) projects, Epic, Data Warehouse, physician and clinical time studies or time cards, facility costs.</td>
<td>Improvement Target: Cost Effectiveness of rheumatology procedures as determined by PDSA in DY 3</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment (maximum amount): $14,802</td>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $17,157.25</td>
<td>Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)</td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td>Process Milestone 2 Estimated Incentive Payment: $17,157.25</td>
<td>Estimated Incentive Payment: $55,063</td>
</tr>
<tr>
<td>Process Milestone 2 [P-3]: Test Data System</td>
<td>Process Milestone 2 Estimated Incentive Payment: $17,157.25</td>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $29,604</td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td>ите: $29,604</td>
<td>Year 3 Estimated Outcome Amount: $34,314.50</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td>Year 3 Estimated Outcome Amount: $34,314.50</td>
<td>Year 4 Estimated Outcome Amount: $55,063</td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount:</td>
<td>Year 4 Estimated Outcome Amount: $55,063</td>
<td>Year 5 Estimated Outcome Amount: $131,672.5</td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount:</td>
<td>Year 5 Estimated Outcome Amount: $131,672.5</td>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $250,654</td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount:</td>
<td>ите: $250,654</td>
<td></td>
</tr>
</tbody>
</table>
**Title of Outcome Measure (Improvement Target):** OD-5: Cost of Care

**Unique RHP outcome identification number:** 139135109.3.8/Texas Children’s Hospital

**Outcome Measure Description:**
OD-5: Cost of Care  
IT-5.2 Per Episode of Care

**Process milestone:**
DY 2 P-1; P-3  
DY3 P-4; P-5

**Outcome Improvement Targets for each year:**
DY 4 IT-5.2;  
DY 5 IT-5.2

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline costs, whether high or low, will dictate an appropriate improvement target goal.

We agree with the TX HHSC DSRIP project’s goals of this waiver specific to cost of care. Our project will strive to develop better and more robust cost-of-care measures to help those who receive care, provide care and pay for care understand how pediatric providers, especially, pediatric subspecialists, use resources and compare these costs to local, regional or national benchmarks when available.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year

(“QALY”) per year and a percentage of that QALY for the pediatric population.² The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 2 [P-3]: Test Data System</td>
<td>Process Milestone 2 [P-3]: Test Data System</td>
<td>Process Milestone 2 Estimated Incentive Payment: $17,157.25</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $29,604</td>
<td>Year 3 Estimated Outcome Amount: $34,314.50</td>
<td>Year 4 Estimated Outcome Amount: $55,063</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $29,604</td>
<td>Year 3 Estimated Outcome Amount: $34,314.50</td>
<td>Year 4 Estimated Outcome Amount: $55,063</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $250,654</td>
<td>Year 5 Estimated Outcome Amount: $131,672.5</td>
<td>Year 5 Estimated Outcome Amount: $131,672.5</td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.9/Texas Children’s Hospital

Outcome Measure Description:
OD-5: Cost of Care
IT-5.3 Length of Stay

Process milestone:
DY 2 P-1; P-3
DY 3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.3;
DY 5 IT-5.3

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

We have specifically identified reduction in Length of Stay as one of our quality outcomes as this measure has the highest resource consumption for a patient (barring any complications due to comorbidities or severity of illness). We hope to demonstrate that a reduction in length of stay allows for a better use of existing resources and hospital capacity, thus enabling us to serve more patients in less time currently required. Ultimately, this not only improves costs but also patient satisfaction in the care provided. Because we are caring for children, this is of utmost importance – to not keep the child away from his or her home for any unnecessary length of time due to inefficiencies in care delivery and coordination of discharge.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is


used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
<table>
<thead>
<tr>
<th>Year</th>
<th>Starting Point/Baseline</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1] Project Planning</strong></td>
<td>Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Conduct PDSA by subspecialty clinic to determine the subpopulation of Rheumatology patients with the greatest opportunity for LOS reduction to establish a baseline</td>
<td>Using identified subset population in from process milestone 3 attempt to reduce or maintain ALOS for admissions compared to baseline</td>
<td>Using identified subset population in from process milestone 3 attempt to reduce or maintain ALOS for admissions compared to baseline</td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td>Data Source: Advanced Quality Improvement (AQI) projects, Press Ganey Survey, Epic and Enterprise Data Warehouse</td>
<td>Data Source: EPIC Medical Record, Enterprise Data Warehouse</td>
<td>Data Source: EPIC Medical Record, Enterprise Data Warehouse</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]: Test Data System</strong></td>
<td>Use Enterprise Data Warehouse reports</td>
<td>Use Enterprise Data Warehouse reports</td>
<td>Use Enterprise Data Warehouse reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 1 Estimated Incentive Payment (maximum amount):</strong> $14,802</td>
<td><strong>Process Milestone 1 Estimated Incentive Payment (maximum amount):</strong> $17,157.25</td>
<td><strong>Process Milestone 2 Estimated Incentive Payment:</strong> $17,157.25</td>
<td><strong>Outcome Improvement Target 3 [IT-5.3]</strong> Attempt to reduce or maintain ALOS for admissions compared to baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $34,314.50</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $55,063</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $55,063</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $131,672.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>139135109.1.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $250,654*
**Title of Outcome Measure (Improvement Target):** Cost of Care

**Unique RHP outcome identification number:** 139135109.3.10/Texas Children’s Hospital

**Outcome Measure Description:** Cost of Care

- IT-5.1 Improved cost savings: Cost Effectiveness Analysis

**Process milestone:**
- DY 2 P-1; P-3
- DY3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT-5.1;
- DY 5 IT-5.1

**Rationale:**
Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

“The central purpose of cost-effectiveness analysis (CEA) is to compare the costs and the values of different health care interventions in creating better health and longer life. Many new medical devices, procedures, diagnostic tests, and prescription drugs are expensive; cost-effectiveness analysis can help to evaluate whether the improvement in health care outcomes justifies the expenditures relative to other choices.” (Focus on Cost-Effectiveness Analysis at AHRQ: Fact Sheet. August 2001. Agency for Healthcare Research and Quality, Rockville, MD. [http://www.ahrq.gov/research/findings/factsheets/costeff.html](http://www.ahrq.gov/research/findings/factsheets/costeff.html))

Cost effectiveness studies empower policy makers, hospital administrators, care providers and patients in prioritizing where finite health care dollars should be spent and what evidence-based protocols, medicines, technology and equipment should be combined in response to a population’s most compelling health need. In our project, this population is chronically ill children.

We hope to utlize the Center for Clinic Effectiveness at Baylor College of Medicine and Texas Children’s Hospital in coordinating many of our quality studies for the Waiver. Specifically, the Center is developing “score cards” of various chronic disease care models to improve our patient-centered care resources. The goal is to establish evidence-based, structured approaches to various clinical procedures while simultaneously reducing variation in clinical practice and improve clinical and health outcomes.
Outcome Measure Valuation:
All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.² The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Process Milestone 1 [P-1] Project Planning** – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
Data Source: EHR/Business Intelligence  
Process Milestone 1 Estimated Incentive Payment (maximum amount): $16,088.50  
**Process Milestone 2 [P-3]: Test Data System**  
Data Source: Enterprise Data Warehouse reports  
Process Milestone 2 Estimated Incentive Payment: $16,088.50 | **Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic on a Cardiology process, procedure or test to improve efficiencies and subsequently costs.**  
Data Source: Advanced Quality Improvement (AQI) projects, Epic, Data Warehouse, physician and clinical time studies or time cards, facility costs.  
**Data Source:** Advanced Quality Improvement (AQI) projects  
Process Milestone 3 Estimated Incentive Payment: $18,648.75  
**Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders  
Data Source: Reports and participation in learning collaboratives  
Process Milestone 4 Estimated Incentive Payment: $18,648.75 | **Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery**  
Improvement Target: Cost Effectiveness of cardiology procedures as determined by PDSA in DY 3  
Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)  
Outcome Improvement Target 1 Estimated Incentive Payment: $59,849.25  
**Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery**  
Improvement Target: Cost Effectiveness of cardiology procedures as determined by PDSA in DY 3  
Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)  
Outcome Improvement Target 1 Estimated Incentive Payment: $143,117.50 |  

**Related Category 1 or 2 Projects::**

Starting Point/Baseline: **TBD in DY 3**

**Texas Children’s Hospital**
<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td><strong>Texas Children’s Hospital</strong></td>
<td><strong>139135109.1.4</strong></td>
<td><strong>TBD in DY 3</strong></td>
<td><strong>139135109</strong></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $32,177</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount: $37,297.50</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount: $59,849.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount: $143,117.50</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $272,441.25*
**Title of Outcome Measure (Improvement Target):** Cost of Care

**Unique RHP outcome identification number:** 139135109.3.11/Texas Children’s Hospital

**Outcome Measure Description:** Cost of Care

IT-5.2 Per Episode of Care:

**Process milestone:**
- DY 2 P-1; P-3
- DY3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT-5.2;
- DY 5 IT-5.2

**Rationale:**
Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

We agree with the TX HHSC DSRIP project’s goals of this waiver specific to cost of care. Our project will strive to develop better and more robust cost-of-care measures to help those who receive care, provide care and pay for care understand how pediatric providers, especially, pediatric subspecialists, use resources and compare these costs to local, regional or national benchmarks when available.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is a only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Outcome Measure Valuation:**
All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We

---

used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>139135109.1.4</th>
<th>Cost of Care</th>
<th>139135109</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic&lt;br&gt;<strong>Data Source</strong>: Advanced Quality Improvement (AQI) projects</td>
<td>Outcome Improvement Target 2 [IT-5.2] Per episode cost of care&lt;br&gt;Improvement Target: Determine cost of episode of care for high volume or high complexity service such as single ventricle or heart transplant&lt;br&gt;a. Numerator: total cost for episode of care&lt;br&gt;b. Denominator: total number of episodes in one month/year&lt;br&gt;c. <strong>Data Source</strong>: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system)</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $16,088.50</td>
<td>Process Milestone 3 Estimated Incentive Payment: $18,648.75</td>
<td></td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $59,849.25</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]: Test Data System</strong>&lt;br&gt;Data Source: Enterprise Data Warehouse reports</td>
<td><strong>Process Milestone 4 [P-5]:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders&lt;br&gt;Data Source: Reports and participation in learning collaboratives</td>
<td>Process Milestone 4 Estimated Incentive Payment: $18,648.75</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $16,088.50</td>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $32,177</td>
<td>Year 3 Estimated Outcome Amount: $37,297.50</td>
<td>Year 4 Estimated Outcome Amount: $59,849.25</td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong>: (add outcome amounts over DYs 2-5): $272,441.25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): Cost of Care

Unique RHP outcome identification number: 139135109.3.12/Texas Children’s Hospital

Outcome Measure Description: Cost of Care
   IT-5.3 Length of Stay:

Process milestone:
   DY 2 P-1; P-3
   DY3 P-4; P-5

Outcome Improvement Targets for each year:
   DY 4 IT-5.3;
   DY 5 IT-5.3

Rationale:
Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We have specifically identified reduction in Length of Stay as one of our quality outcomes as this measure has the highest resource consumption for a patient (barring any complications due to comorbidities or severity of illness). We hope to demonstrate that a reduction in length of stay allows for a better use of existing resources and hospital capacity, thus enabling us to serve more patients in less time currently required. Ultimately, this not only improves costs but also patient satisfaction in the care provided. Because we are caring for children, this is of utmost importance – to not keep the child away from his or her home for any unnecessary length of time due to inefficiencies in care delivery and coordination of discharge.

Outcome Measure Valuation:
All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.² The QALY is used as a one-time improvement in the

quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>Starting Point/Baseline:</th>
<th>Cost of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Children’s Hospital</td>
<td>139135109.4</td>
<td>139135109</td>
</tr>
</tbody>
</table>

### Year 2
(10/1/2012 – 9/30/2013)

- **Process Milestone 1 [P-1] Project Planning** – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - Data Source: EHR/Business Intelligence

  - Process Milestone 1 Estimated Incentive Payment (maximum amount): $16,088.50

### Year 3
(10/1/2013 – 9/30/2014)

- **Process Milestone 2 [P-3]: Test Data System**
  - Data Source: Enterprise Data Warehouse reports

  - Process Milestone 2 Estimated Incentive Payment: $16,088.50

- **Process Milestone 3 [P-4]: Conduct PDSA by subspecialty clinic to determine the subpopulation of Cardiology patients with the greatest opportunity for LOS reduction to establish a baseline**
  - Data Source: Advanced Quality Improvement (AQI) projects, Press Ganey Survey, Epic and Enterprise Data Warehouse

  - Process Milestone 3 Estimated Incentive Payment: $18,648.75

### Year 4
(10/1/2014 – 9/30/2015)

- **Outcome Improvement Target 3 [IT-5.3]: Using identified subset population from process milestone 3 attempt to reduce or maintain ALOS for admissions compared to baseline**
  - Data Source: EPIC Medical Record, Enterprise Data Warehouse

  - Outcome Improvement Target 3 Estimated Incentive Payment: $59,849.25

### Year 5
(10/1/2015 – 9/30/2016)

- **Outcome Improvement Target 3 [IT-5.3]: Using identified subset population from process milestone 3 attempt to reduce or maintain ALOS for admissions compared to baseline**
  - Data Source: EPIC Medical Record, Enterprise Data Warehouse

  - Outcome Improvement Target 3 Estimated Incentive Payment: $143,117.50
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>139135109.1.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td>Year 3 Estimated Outcome Amount:</td>
<td>Year 4 Estimated Outcome Amount:</td>
<td>Year 5 Estimated Outcome Amount:</td>
</tr>
<tr>
<td>(add incentive payments amounts</td>
<td>(add incentive payments amounts</td>
<td>(add incentive payments amounts</td>
<td>(add incentive payments amounts</td>
</tr>
<tr>
<td>from each milestone/outcome</td>
<td>from each milestone/outcome</td>
<td>from each milestone/outcome</td>
<td>from each milestone/outcome</td>
</tr>
<tr>
<td>improvement target): $32,177</td>
<td>$37,297.50</td>
<td>$59,849.25</td>
<td>$143,117.50</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $272,441.25
Title of Outcome Measure (Improvement Target): Cost of Care

Unique RHP outcome identification number: 139135109.3.13/Texas Children’s Hospital

Outcome Measure Description:
OD-5: Cost of Care
IT-5.1 Improved cost savings: Cost Effectiveness

Process milestone:
  DY 2 P-1; P-3
  DY3 P-4; P-5

Outcome Improvement Targets for each year:
  DY 4 IT-5.1;
  DY 5 IT-5.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline costs, whether high or low, will dictate an appropriate improvement target goal.

“The central purpose of cost-effectiveness analysis (CEA) is to compare the costs and the values of different health care interventions in creating better health and longer life. Many new medical devices, procedures, diagnostic tests, and prescription drugs are expensive; cost-effectiveness analysis can help to evaluate whether the improvement in health care outcomes justifies the expenditures relative to other choices.” (Focus on Cost-Effectiveness Analysis at AHRQ: Fact Sheet. August 2001. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/findings/factsheets/costeff.html)

Cost effectiveness studies empower policy makers, hospital administrators, care providers and patients in prioritizing where finite health care dollars should be spent and what evidence-based protocols, medicines, technology and equipment should be combined in response to a population’s most compelling health need. In our project, this population is chronically ill children.

We hope to utilize the Center for Clinic Effectiveness at Baylor College of Medicine and Texas Children’s Hospital in coordinating many of our quality studies for the Waiver. Specifically, the Center is developing “score cards” of various chronic disease care models to improve our patient-centered care resources. The goal is to establish evidence-based, structured approaches to
various clinical procedures while simultaneously reducing variation in clinical practice and improve clinical and health outcomes.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. ¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. ² The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---


<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>139135109.1.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>139135109.3.13</th>
<th>IT- 5.1</th>
<th>Cost of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Texas Children’s Hospital</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
<td>TBD in DY 3</td>
<td>TBD in DY 3</td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-1]</strong></td>
<td><strong>Process Milestone 3 [P-4]</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
<td><strong>Outcome Improvement Target 1</strong></td>
</tr>
<tr>
<td>Project Planning</td>
<td>Conduct PDSA by subspecialty clinic on a Pulmonology process, procedure or test to improve efficiencies and subsequently costs.</td>
<td>Improved cost savings: Demonstrate cost savings in care delivery</td>
<td>Improved cost savings: Demonstrate cost savings in care delivery</td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td>Data Source: Advanced Quality Improvement (AQI) projects, Epic, Data Warehouse, physician and clinical time studies or time cards, facility costs.</td>
<td>Improvement Target: Cost Effectiveness of pulmonology procedures as determined by PDSA in DY 3</td>
<td>Improvement Target: Cost Effectiveness of pulmonology procedures as determined by PDSA in DY 3</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $15,881.25</td>
<td>Process Milestone 3 Estimated Incentive Payment: $18,408.50</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $59,078.25</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $141,274.00</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]</strong></td>
<td><strong>Process Milestone 4 [P-5]</strong>: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>Process Milestone 4 Estimated Incentive Payment: $18,408.50</td>
<td>Process Milestone 4 Estimated Incentive Payment: $18,408.50</td>
</tr>
<tr>
<td>Test Data System</td>
<td>Data Source: Reports and participation in learning collaboratives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td>Process Milestone 4 Estimated Incentive Payment: $18,408.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>139135109.1.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $31,762.50</td>
<td>Year 3 Estimated Outcome Amount: $36,817</td>
<td>Year 4 Estimated Outcome Amount: $59,078.25</td>
<td>Year 5 Estimated Outcome Amount: $141,274.00</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $268,931.75*
Title of Outcome Measure (Improvement Target): Cost of Care

Unique RHP outcome identification number: 139135109.3.14/Texas Children’s Hospital

Outcome Measure Description:
OD-5: Cost of Care
IT-5.2 Per Episode of Care

Process milestone:
  DY 2 P-1; P-3
  DY 3 P-4; P-5

Outcome Improvement Targets for each year:
  DY 4 IT-5.2;
  DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline costs, whether high or low, will dictate an appropriate improvement target goal.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

We agree with the TX HHSC DSRIP project’s goals of this waiver specific to cost of care. Our project will strive to develop better and more robust cost-of-care measures to help those who receive care, provide care and pay for care understand how pediatric providers, especially, pediatric subspecialists, use resources and compare these costs to local, regional or national benchmarks when available.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year.

---

(“QALY”) per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1] Project Planning</th>
<th>Process Milestone 2 [P-3]: Test Data System</th>
<th>Process Milestone 3 [P-4]: Conduct PDSA by subspecialty clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong> TBD in DY 3</td>
<td><strong>Data Source:</strong> Enterprise Data Warehouse reports</td>
<td><strong>Data Source:</strong> Advanced Quality Improvement (AQI) projects</td>
</tr>
<tr>
<td><strong>Year 2 (10/1/2012 – 9/30/2013)</strong></td>
<td><strong>Process Milestone 4 [P-5]:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Process Milestone 3 Estimated Incentive Payment:</strong> $18,408.50</td>
</tr>
<tr>
<td><strong>Process Milestone 1 Estimated Incentive Payment (maximum amount):</strong> $15,881.25</td>
<td><strong>Data Source:</strong> Reports and participation in learning collaboratives</td>
<td><strong>Process Milestone 4 Estimated Incentive Payment:</strong> $18,408.50</td>
</tr>
<tr>
<td><strong>Process Milestone 2 Estimated Incentive Payment:</strong> $15,881.25</td>
<td><strong>Outcome Improvement Target 2 [IT-5.2]:</strong> Per episode cost of care</td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong> $59,078.25</td>
</tr>
</tbody>
</table>

**Outcome Improvement Target 2 [IT-5.2]:** Per episode cost of care
Improvement Target: Determine cost of episode of care for high volume or high complexity service such as pediatric asthma

a. Numerator: total cost for episode of care
b. Denominator: total number of episodes in one month/year
c. Data Source: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system)

**Year 2 Estimated Outcome Amount:** $36,817

**Year 3 Estimated Outcome Amount:** $36,817

**Year 4 Estimated Outcome Amount:** $59,078.25

**Year 5 Estimated Outcome Amount:** $141,274.00

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $268,931.75
**Title of Outcome Measure (Improvement Target):** Cost of Care

**Unique RHP outcome identification number:** 139135109.3.15/Texas Children’s Hospital

**Outcome Measure Description:**
OD-5: Cost of Care  
IT-5.3 Length of Stay

**Process milestone:**
- DY 2 P-1; P-3
- DY 3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT-5.3;
- DY 5 IT-5.3

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY 4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY 3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

We have specifically identified reduction in Length of Stay as one of our quality outcomes as this measure has the highest resource consumption for a patient (barring any complications due to comorbidities or severity of illness). We hope to demonstrate that a reduction in length of stay allows for a better use of existing resources and hospital capacity, thus enabling us to serve more patients in less time currently required. Ultimately, this not only improves costs but also patient satisfaction in the care provided. Because we are caring for children, this is of utmost importance – to not keep the child away from his or her home for any unnecessary length of time due to inefficiencies in care delivery and coordination of discharge.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in
emergency room visits and reduction in inpatient hospital visits. Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---


<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1] Project Planning</td>
<td>Process Milestone 3 [P-4]</td>
<td>Outcome Improvement Target 3 [IT-5.3]</td>
<td>Outcome Improvement Target 3 [IT-5.3]</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Planning</td>
<td>Conduct PDSA by subspecialty clinic to determine the subpopulation of Pulmonology patients with the greatest opportunity for LOS reduction to establish a baseline</td>
<td>Using identified subset population from process milestone 3 attempt to reduce or maintain ALOS for admissions compared to baseline</td>
<td>Using identified subset population from process milestone 3 attempt to reduce or maintain ALOS for admissions compared to baseline</td>
</tr>
<tr>
<td></td>
<td>– Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Data Source: Advanced Quality Improvement (AQI) projects, Press Ganey Survey, Epic and Enterprise Data Warehouse</td>
<td>Data Source: EPIC Medical Record, Enterprise Data Warehouse</td>
<td>Data Source: EPIC Medical Record, Enterprise Data Warehouse</td>
</tr>
<tr>
<td></td>
<td>Data Source: EHR/Business Intelligence</td>
<td>Goal: Establish ALOS and related patient satisfaction baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount):</td>
<td>Process Milestone 3 Estimated Incentive Payment:</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment:</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$15,881.25</td>
<td>$18,408.50</td>
<td>$59,078.25</td>
<td>$141,274.00</td>
</tr>
<tr>
<td>Process Milestone 2 [P-3]: Test Data System</td>
<td>Process Milestone 4 Estimated Incentive Payment:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td>$18,408.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment:</td>
<td>Process Milestone 4 Estimated Incentive Payment:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$15,881.25</td>
<td>$18,408.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>139135109.1.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt; (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt; (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong>&lt;br&gt; (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong>&lt;br&gt; (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $31,762.50</td>
<td>Year 3 Estimated Outcome Amount: $36,817</td>
<td>Year 4 Estimated Outcome Amount: $59,078.25</td>
<td>Year 5 Estimated Outcome Amount: $141,274.00</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $268,931.75*
Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.16/Texas Children’s Hospital

Outcome Measure Description:
IT-5.1 Improved cost savings:

Process milestone:
   DY 2 P-1; P-3
   DY3 P-4; P-5

Outcome Improvement Targets for each year:
   DY 4 IT-5.1;
   DY 5 IT-5.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---


<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Cost of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Children’s Hospital</td>
<td>139135109.1.6</td>
</tr>
</tbody>
</table>

Starting Point/Baseline: TBD in DY 3

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic Data Source: Advanced Quality Improvement (AQI) projects</td>
<td>Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: Cost Effectiveness of Ophthalmology surgical procedures Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)</td>
<td>Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: Cost Effectiveness of Ophthalmology surgical procedures Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]: Test Data System</strong> Data Source: Enterprise Data Warehouse reports</td>
<td><strong>Process Milestone 4 [P-5]:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $18,081.75</td>
<td>Process Milestone 4 Estimated Incentive Payment: $20,959.25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $36,163.50 | Year 3 Estimated Outcome Amount: $41,918.50 | Year 4 Estimated Outcome Amount: $67,264.25 | Year 5 Estimated Outcome Amount: $160,849 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $306,195.25
**Title of Outcome Measure (Improvement Target):** OD-5: Cost of Care

**Unique RHP outcome identification number:** 139135109.3.17/Texas Children’s Hospital

**Outcome Measure Description:**
IT-5.2 Per Episode of Care

**Process milestone:**
- DY 2 P-1; P-3
- DY3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT-5.2;
- DY 5 IT-5.2

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline cost, whether high or low, will dictate an appropriate improvement target goal. We agree with the TX HHSC DSRIP project’s goals of this waiver specific to cost of care. Our project will strive to develop better and more robust cost-of-care measures to help those who receive care, provide care and pay for care understand how pediatric providers, especially, pediatric subspecialists, use resources and compare these costs to local, regional or national benchmarks when available.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year

---

(“QALY”) per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Cost of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Children’s Hospital</td>
<td>139135109.1.6</td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>TBD in DY 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Process Milestone 1 [P-1] Project Planning**  
Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
Data Source: EHR/Business Intelligence | **Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic**  
Data Source: Advanced Quality Improvement (AQI) projects  
Process Milestone 3 Estimated Incentive Payment: $20,959.25 | **Outcome Improvement Target 2 [IT-5.2] Per episode cost of care**  
Improvement Target: Determine cost of episode of care for high volume or high complexity ophthalmology surgical service  
a. Numerator: total cost for episode of care  
b. Denominator: total number of episodes in one month/year  
c. Data Source: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system)  
Outcome Improvement Target 2 Estimated Incentive Payment: $67,264.25 | **Outcome Improvement Target 2 [IT-5.2] Per episode cost of care**  
Improvement Target: Select specific high volume or high complexity ophthalmology surgical service to maintain or diminish per episode cost of care  
a. Numerator: total cost for episode of care  
b. Denominator: total number of episodes in one month/year  
c. Data Source: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system)  
Outcome Improvement Target 2 Estimated Incentive Payment: $160,849 |
| Process Milestone 1 Estimated Incentive Payment (maximum amount): $18,081.75 | **Process Milestone 4 [P-5]:**  
Disseminate findings, including lessons learned and best practices, to stakeholders  
Data Source: Reports and participation in learning collaboratives  
Process Milestone 4 Estimated Incentive Payment: $20,959.25 | **Year 2 Estimated Outcome Amount:** (add incentive payments amounts from each milestone/outcome improvement target): $36,163.50 | **Year 3 Estimated Outcome Amount:** $41,918.50 |
| **Process Milestone 2 [P-3]: Test Data System**  
Data Source: Enterprise Data Warehouse reports | **Process Milestone 4 Estimated Incentive Payment:** $20,959.25 | **Year 4 Estimated Outcome Amount:** $67,264.25 | **Year 5 Estimated Outcome Amount:** $160,849 |
| Process Milestone 2 Estimated Incentive Payment: $18,081.75 | **Outcomes Improvement Target 2**  
Estimated Incentive Payment: $67,264.25 | **Outcomes Improvement Target 2**  
Estimated Incentive Payment: $160,849 | **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $306,195.25 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $306,195.25
**Title of Outcome Measure (Improvement Target):** OD-5: Cost of Care

**Unique RHP outcome identification number:** 139135109.3.18/Texas Children’s Hospital

**Outcome Measure Description:**
IT-5.3 (Other Outcome Improvement Target) Length of Stay Reduce Unplanned Re-operations

**Process milestone:**
- DY 2 P-1; P-3
- DY 3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT-5.3;
- DY 5 IT-5.3

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY 4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY 3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. We agree that increased access should be coupled with controlling unnecessary costs, especially, if these costs are associated with an unplanned reoperation of a child.

The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has suggested that unplanned reoperations could be tracked as a “screening tool” for quality assurance. A current research article published by a team of surgeons at Dartmouth-Hitchcock Medical Center, the Veteran’s Affairs Quality Group, the department of Surgery at Dartmouth Medical School and the Department of Veteran Affairs entitled, “Is Unplanned Return to the Operating Room a Useful Quality Indicator in General Surgery?” recommends that unplanned reoperations have important implications for patients – not only their health outcomes but also their safety and overall satisfaction with the care they receive. Regarding patient safety, an unplanned reoperation may result in a higher mortality and, “… certain patient-related and procedure-related factors increase risk.”

In the research, it was acknowledged that unplanned surgeries are obviously, not the choice of a patient or family member and that such events are usually isolated incidents. However, as a leader in providing regional access to tertiary and quaternary services to children, we must constantly strive to provide care that is effective and safe. As we measure our access to
subspecialty surgical services, we hope to establish quality of care models for our pediatric patients that provide a high rate of return. We believe that tracking unplanned reoperations will greatly assist us in these efforts.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>139135109.1.6</th>
<th>139135109</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>TBD in DY 3</strong></td>
<td><strong>10/1/2012 – 9/30/2013</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount):</td>
<td>$18,081.75</td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount):</td>
<td>$18,081.75</td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount):</td>
<td>$18,081.75</td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount):</td>
<td>$18,081.75</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]: Test Data System</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment:</td>
<td>$18,081.75</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 3 [P-4]: Conduct PDSA by subspecialty clinic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Advanced Quality Improvement (AQI) projects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment:</td>
<td>$20,959.25</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 4 [P-5]:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Reports and participation in learning collaboratives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 4 Estimated Incentive Payment:</td>
<td>$20,959.25</td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 3 [IT-5.3] Reduce Unplanned Reoperations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement Target: Track and/or reduce unplanned re-operations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement Target: Determine a specific high acuity or high complexity procedure that required re-operation and design a clinical and quality course of action to prevent, not increase or reduce this outcome over time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numerator: # of unplanned reoperations identified by acuity or complexity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: Total # of operations by identified high acuity or high complexity procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EPIC Medical Record Enterprise Data Warehouse (contains clinical and financial data for integrated system), database created by newly hired Outcomes research nurse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 4 Estimated Incentive Payment:</td>
<td>$20,959.25</td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 3 Estimated Incentive Payment:</strong></td>
<td>$67,264.25</td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 3 Estimated Incentive Payment:</strong></td>
<td>$160,849</td>
<td></td>
</tr>
</tbody>
</table>
139135109.3.18 | IT- 5.3 | Cost of Care Reduce Unplanned Reoperations
| Texas Children’s Hospital | | 139135109

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>139135109.1.6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $36,163.50</td>
<td>Year 3 Estimated Outcome Amount: $41,918.50</td>
<td>Year 4 Estimated Outcome Amount: $67,264.25</td>
<td>Year 5 Estimated Outcome Amount: $160,849</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $306,195.25*
Title of Outcome Measure (Improvement Target): Cost of Care

Unique RHP outcome identification number: 139135109.3.19/Texas Children’s Hospital

Outcome Measure Description:
OD-5: Cost of Care
   IT-5.1 Improved cost savings: Cost Effectiveness

Process milestone:
   DY 2 P-1; P-3
   DY 3 P-4; P-5

Outcome Improvement Targets for each year:
   DY 4 IT-5.1;
   DY 5 IT-5.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY 4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY 3. The baseline costs, whether high or low, will dictate an appropriate improvement target goal.

“The central purpose of cost-effectiveness analysis (CEA) is to compare the costs and the values of different health care interventions in creating better health and longer life. Many new medical devices, procedures, diagnostic tests, and prescription drugs are expensive; cost-effectiveness analysis can help to evaluate whether the improvement in health care outcomes justifies the expenditures relative to other choices.” (Focus on Cost-Effectiveness Analysis at AHRQ: Fact Sheet. August 2001. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/findings/factsheets/costeff.html)

Cost effectiveness studies empower policy makers, hospital administrators, care providers and patients in prioritizing where finite health care dollars should be spent and what evidence-based protocols, medicines, technology and equipment should be combined in response to a population’s most compelling health need. In our project, this population is chronically ill children.

We hope to utlize the Center for Clinic Effectiveness at Baylor College of Medicine and Texas Children’s Hospital in coordinating many of our quality studies for the Waiver. Specifically, the Center is developing “score cards” of various chronic disease care models to improve our patient-centered care resources. The goal is to establish evidence-based, structured approaches to
various clinical procedures while simultaneously reducing variation in clinical practice and improve clinical and health outcomes.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.

---


<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Process Milestone 1 [P-1]** Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
Data Source: EHR/Business Intelligence  
Process Milestone 1 Estimated Incentive Payment *(maximum amount)*: $31,599.50 | **Process Milestone 3 [P-4]** Conduct PDSA by subspecialty clinic on a gastroenterology process, procedure or test to improve efficiencies and subsequently costs.  
Data Source: Advanced Quality Improvement (AQI) projects, Epic, Data Warehouse, physician and clinical time studies or time cards, facility costs.  
Process Milestone 3 Estimated Incentive Payment: $36,627.50 | **Outcome Improvement Target 1 [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery  
Improvement Target: : Cost Effectiveness of gastroenterology procedures as determined by PDSA in DY 3  
Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)  
Outcome Improvement Target 1 Estimated Incentive Payment: $117,549 | **Outcome Improvement Target 1 [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery  
Improvement Target: : Cost Effectiveness of gastroenterology procedures as determined by PDSA in DY 3  
Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)  
Outcome Improvement Target 1 Estimated Incentive Payment: $533,595.50 |
| **Process Milestone 2 [P-3]**: Test Data System  
Data Source: Enterprise Data Warehouse reports  
Process Milestone 2 Estimated Incentive Payment: $31,599.50 | **Process Milestone 4 [P-5]**: Disseminate findings, including lessons learned and best practices, to stakeholders  
Data Source: Reports and participation in learning collaboratives  
Process Milestone 4 Estimated Incentive Payment: $36,627.50 | **Year 2 Estimated Outcome Amount**: (add incentive payments amounts from each milestone/outcome improvement target): $63,198.50 | **Year 3 Estimated Outcome Amount**: $73,255 |
<p>| <strong>Year 3 Estimated Outcome Amount</strong>: $117,549 | <strong>Year 4 Estimated Outcome Amount</strong>: $117,549 | <strong>Year 4 Estimated Outcome Amount</strong>: $533,595.50 | <strong>Year 5 Estimated Outcome Amount</strong>: $533,595.50 |</p>
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>139135109.3.19</th>
<th>IT- 5.1</th>
<th>Cost of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Texas Children’s Hospital]</td>
<td>139135109.1.7</td>
<td></td>
<td>139135109</td>
</tr>
</tbody>
</table>

Starting Point/Baseline:

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYS 2-5): $787,598.25*
Title of Outcome Measure (Improvement Target): Cost of Care

Unique RHP outcome identification number: 139135109.3.20/Texas Children’s Hospital

Outcome Measure Description:
OD-5: Cost of Care
   IT-5.2 Per episode of care

Process milestone:
   DY 2 P-1; P-3
   DY3 P-4; P-5

Outcome Improvement Targets for each year:
   DY 4 IT5.2
   DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline costs, whether high or low, will dictate an appropriate improvement target goal.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The Affordable Care Act focused on the triple aim - improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

We agree with the TX HHSC DSRIP project’s goals of this waiver specific to cost of care. Our project will strive to develop better and more robust cost-of-care measures to help those who receive care, provide care and pay for care understand how pediatric providers, especially, pediatric subspecialists, use resources and compare these costs to local, regional or national benchmarks when available.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year

(“QALY”) per year and a percentage of that QALY for the pediatric population.\textsuperscript{2} The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.\textsuperscript{3}

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source</strong>: EHR/Business Intelligence</td>
<td><strong>Data Source</strong>: Enterprise Data Warehouse reports</td>
<td><strong>Data Source</strong>: Advanced Quality Improvement (AQI) projects</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment <em>(maximum amount)</em>: $31,599.50</td>
<td>Process Milestone 2 Estimated Incentive Payment: $31,599.50</td>
<td>Process Milestone 3 Estimated Incentive Payment: $36,627.50</td>
</tr>
</tbody>
</table>

**Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders

**Data Source**: Reports and participation in learning collaboratives

Process Milestone 4 Estimated Incentive Payment: $36,627.50

<table>
<thead>
<tr>
<th>Outcome Improvement Target 2 [IT-5.2] Per episode cost of care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improvement Target</strong>: Determine cost of episode of care for high volume or high complexity service such as IBD</td>
</tr>
<tr>
<td><strong>a. Numerator</strong>: total cost for episode of care</td>
</tr>
<tr>
<td><strong>b. Denominator</strong>: total number of episodes in one month/year</td>
</tr>
<tr>
<td><strong>c. Data Source</strong>: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system)</td>
</tr>
</tbody>
</table>

Outcome Improvement Target 2 Estimated Incentive Payment: $117,549

<table>
<thead>
<tr>
<th>Outcome Improvement Target 2 [IT-5.2] Per episode cost of care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improvement Target</strong>: Determine cost of episode of care for high volume or high complexity service such as IBD</td>
</tr>
<tr>
<td><strong>a. Numerator</strong>: total cost for episode of care</td>
</tr>
<tr>
<td><strong>b. Denominator</strong>: total number of episodes in one month/year</td>
</tr>
<tr>
<td><strong>c. Data Source</strong>: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system)</td>
</tr>
</tbody>
</table>

Outcome Improvement Target 2 Estimated Incentive Payment: $533,595.50

**Year 3 Estimated Outcome Amount**: $73,255

**Year 4 Estimated Outcome Amount**: $117,549

**Year 5 Estimated Outcome Amount**: $533,595.50

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5)*: $787,598.25
Title of Outcome Measure (Improvement Target): Cost of Care

Unique RHP outcome identification number: 139135109.3.21/Texas Children’s Hospital

Outcome Measure Description:
OD-5: Cost of Care
IT-5.3 Length of stay

Process milestone:
DY 2 P-1; P-3
DY 3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.3
DY 5 IT-5.3

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY 4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY 3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

We have specifically identified reduction in Length of Stay as one of our quality outcomes as this measure has the highest resource consumption for a patient (barring any complications due to comorbidities or severity of illness). We hope to demonstrate that a reduction in length of stay allows for a better use of existing resources and hospital capacity, thus enabling us to serve more patients in less time currently required. Ultimately, this not only improves costs but also patient satisfaction in the care provided. Because we are caring for children, this is of utmost importance – to not keep the child away from his or her home for any unnecessary length of time due to inefficiencies in care delivery and coordination of discharge.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is

---

used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.\textsuperscript{3}
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>139135109.1.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
</tr>
</tbody>
</table>

| Cost of Care | 139135109 |

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]</strong> Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 3 [P-4]</strong> Conduct PDSA by subspecialty clinic to determine the subpopulation of Gastroenterology patients with the greatest opportunity for LOS reduction to establish a baseline</td>
<td><strong>Outcome Improvement Target 3 [IT-5.3]</strong> Using identified subset population from process milestone 3 attempt to reduce or maintain ALOS for admissions compared to baseline</td>
<td><strong>Outcome Improvement Target 3 [IT-5.3]</strong> Using identified subset population from process milestone 3 attempt to reduce or maintain ALOS for admissions compared to baseline</td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td>Data Source: Advanced Quality Improvement (AQI) projects, Press Ganey Survey, Epic and Enterprise Data Warehouse</td>
<td>Data Source: EPIC Medical Record, Enterprise Data Warehouse</td>
<td>Data Source: EPIC Medical Record, Enterprise Data Warehouse</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $31,599.25</td>
<td><strong>Goal:</strong> Establish ALOS and related patient satisfaction baseline</td>
<td><strong>Estimated Incentive Payment:</strong> $117,549</td>
<td><strong>Estimated Incentive Payment:</strong> $533,595.50</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]:</strong> Test Data System</td>
<td><strong>Process Milestone 3 Estimated Incentive Payment:</strong> $36,627.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td><strong>Process Milestone 4: P-5:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $31,599.25</td>
<td>Data Source: Reports and participation in learning collaboratives</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Process Milestone 4 Estimated Incentive Payment: $36,627.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>139135109.1.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(add incentive payments amounts from each milestone/outcome improvement target): $63,198.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount:</td>
<td>$73,255.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount:</td>
<td>$117,549</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount:</td>
<td>$533,595.50</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $787,598.25*
Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.22/Texas Children’s Hospital

Outcome Measure Description:
OD-5: Cost of Care
IT-5.1 Improved cost savings: Cost Effectiveness

Process milestone:
   DY 2 P-1; P-3
   DY 3 P-4; P-5

Outcome Improvement Targets for each year:
   DY 4 IT-5.1
   DY 5 IT-5.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY 4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY 3. The baseline costs, whether high or low, will dictate an appropriate improvement target goal.

“The central purpose of cost-effectiveness analysis (CEA) is to compare the costs and the values of different health care interventions in creating better health and longer life. Many new medical devices, procedures, diagnostic tests, and prescription drugs are expensive; cost-effectiveness analysis can help to evaluate whether the improvement in health care outcomes justifies the expenditures relative to other choices.” (Focus on Cost-Effectiveness Analysis at AHRQ: Fact Sheet. August 2001. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/findings/factsheets/costeff.html)

Cost effectiveness studies empower policy makers, hospital administrators, care providers and patients in prioritizing where finite health care dollars should be spent and what evidence-based protocols, medicines, technology and equipment should be combined in response to a population’s most compelling health need. In our project, this population is chronically ill children.

We hope to utlize the Center for Clinic Effectiveness at Baylor College of Medicine and Texas Children’s Hospital in coordinating many of our quality studies for the Waiver. Specifically, the Center is developing “score cards” of various chronic disease care models to improve our patient-centered care resources. The goal is to establish evidence-based, structured approaches to
various clinical procedures while simultaneously reducing variation in clinical practice and improve clinical and health outcomes.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.\(^3\)

---


<p>| Process Milestone 1 [P-1] Project Planning | Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic on an Endocrinology process, procedure or test to improve efficiencies and subsequently costs. Data Source: Advanced Quality Improvement (AQI) projects, Epic, Data Warehouse, physician and clinical time studies or time cards, facility costs. Process Milestone 3 Estimated Incentive Payment: $36,627.50 | Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: Cost Effectiveness of endocrinology procedures as determined by PDSA in DY 3 Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system) Outcome Improvement Target 1 Estimated Incentive Payment: $117,549 | Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: Cost Effectiveness of endocrinology procedures as determined by PDSA in DY 3 Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system) Outcome Improvement Target 1 Estimated Incentive Payment: $281,095.50 |
| Process Milestone 2 [P-3]: Test Data System Data Source: Enterprise Data Warehouse reports | Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment: $36,627.50 | Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $63,198.50 | Year 3 Estimated Outcome Amount: $73,255 |
| Starting Point/Baseline: TBD in DY 3 | Year 3 Estimated Outcome Amount: $117,549 | Year 4 Estimated Outcome Amount: $117,549 | Year 5 Estimated Outcome Amount: $281,095.50 |
| Related Category 1 or 2 Projects: Texas Children’s Hospital | Year 4 (10/1/2014 – 9/30/2015) | Year 5 (10/1/2015 – 9/30/2016) | |</p>
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>139135109.1.8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
</tr>
</tbody>
</table>
| **Year 2**
  (10/1/2012 – 9/30/2013)        | **Year 3**
  (10/1/2013 – 9/30/2014)        | **Year 4**
  (10/1/2014 – 9/30/2015)        | **Year 5**
  (10/1/2015 – 9/30/2016)        |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5)*: $535,098
**Title of Outcome Measure (Improvement Target):** Cost of Care

**Unique RHP outcome identification number:** 139135109.3.23/Texas Children’s Hospital

**Outcome Measure Description:** OD-5: Cost of Care
IT-5.2 Per Episode of Care

**Process milestone:**
- DY 2 P-1; P-3
- DY 3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT5.2
- DY 5 IT-5.2

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline costs, whether high or low, will dictate an appropriate improvement target goal.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

We agree with the TX HHSC DSRIP project’s goals of this waiver specific to cost of care. Our project will strive to develop better and more robust cost-of-care measures to help those who receive care, provide care and pay for care understand how pediatric providers, especially, pediatric subspecialists, use resources and compare these costs to local, regional or national benchmarks when available.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year

---

(“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.

---

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>139135109.1.8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment <em>(maximum amount)</em>: $31,599.50</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]: Test Data System</strong></td>
<td></td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $31,599.50</td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic Data Source: Advanced Quality Improvement (AQI) projects</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 2 [IT-5.2] Per episode cost of care Improvement Target: Determine cost of episode of care for high volume or high complexity service such as Type 2 diabetes a. Numerator: total cost for episode of care b. Denominator: total number of episodes in one month/year c. Data Source: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system) Outcome Improvement Target 2 Estimated Incentive Payment: $117,549</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 4 Estimated Incentive Payment: $36,627.50</td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td></td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount: $73,255</td>
<td></td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount: $117,549</td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount: $281,095.50</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> *(add outcome amounts over DYs 2-5): $535,098</td>
<td></td>
</tr>
</tbody>
</table>

**Texas Children’s Hospital**

**139135109**

**IT-5.2**

**Cost of Care**

**Year 2 Estimated Outcome Amount:**
*(add incentive payments amounts from each milestone/outcome improvement target): $63,198.50*

**Year 3 Estimated Outcome Amount:**
*(add outcome amounts over DYs 2-5): $535,098*
Title of Outcome Measure (Improvement Target): Cost of Care

Unique RHP outcome identification number: 139135109.3.24/Texas Children’s Hospital

Outcome Measure Description: OD-5: Cost of Care
IT-5.3 Length of Stay

Process milestone:
  DY 2 P-1; P-3
  DY3 P-4; P-5

Outcome Improvement Targets for each year:
  DY 4 IT-5.3;
  DY 5 IT-5.3

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

We have specifically identified reduction in Length of Stay as one of our quality outcomes as this measure has the highest resource consumption for a patient (barring any complications due to comorbidities or severity of illness). We hope to demonstrate that a reduction in length of stay allows for a better use of existing resources and hospital capacity, thus enabling us to serve more patients in less time currently required. Ultimately, this not only improves costs but also patient satisfaction in the care provided. Because we are caring for children, this is of utmost importance – to not keep the child away from his or her home for any unnecessary length of time due to inefficiencies in care delivery and coordination of discharge.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (‘QALY’”) per year and a percentage of that QALY for the pediatric population.² The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality

of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.³
### Related Category 1 or 2 Projects:

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]</strong> Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 3 [P-4]</strong> Conduct PDSA by subspecialty clinic to determine the subpopulation of Endocrinology patients with the greatest opportunity for LOS reduction to establish a baseline</td>
<td><strong>Outcome Improvement Target 3 [IT-5.3]</strong> Using identified subset population from process milestone 3 attempt to reduce or maintain ALOS for admissions compared to baseline</td>
<td><strong>Outcome Improvement Target 3 [IT-5.3]</strong> Using identified subset population from process milestone 3 attempt to reduce or maintain ALOS for admissions compared to baseline</td>
</tr>
<tr>
<td><strong>Data Source:</strong> EHR/Business Intelligence</td>
<td><strong>Data Source:</strong> Advanced Quality Improvement (AQI) projects, Press Ganey Survey, Epic and Enterprise Data Warehouse</td>
<td><strong>Data Source:</strong> EPIC Medical Record, Enterprise Data Warehouse</td>
<td><strong>Data Source:</strong> EPIC Medical Record, Enterprise Data Warehouse</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (<em>maximum amount</em>): $31,599.50</td>
<td>Process Milestone 3 Estimated Incentive Payment: $36,627.50</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $117,549</td>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $281,095.50</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]: Test Data System</strong></td>
<td><strong>Process Milestone 4 [P-5]:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td><strong>Data Source:</strong> Reports and participation in learning collaboratives</td>
<td><strong>Data Source:</strong> Reports and participation in learning collaboratives</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Enterprise Data Warehouse reports</td>
<td><strong>Data Source:</strong> Reports and participation in learning collaboratives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $31,599.50</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Texas Children's Hospital**

139135109.3.2

**Starting Point/Baseline:**

- **Year 2** (10/1/2012 – 9/30/2013)
  - **Process Milestone 1 [P-1]** Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - **Data Source:** EHR/Business Intelligence
  - **Process Milestone 1 Estimated Incentive Payment**: $31,599.50
- **Process Milestone 2 [P-3]: Test Data System**
  - **Data Source:** Enterprise Data Warehouse reports
  - **Process Milestone 2 Estimated Incentive Payment**: $31,599.50

**Year 3** (10/1/2013 – 9/30/2014)

- **Process Milestone 3 [P-4]** Conduct PDSA by subspecialty clinic to determine the subpopulation of Endocrinology patients with the greatest opportunity for LOS reduction to establish a baseline
  - **Data Source:** Advanced Quality Improvement (AQI) projects, Press Ganey Survey, Epic and Enterprise Data Warehouse
  - **Process Milestone 3 Estimated Incentive Payment**: $36,627.50

**Year 4** (10/1/2014 – 9/30/2015)

- **Outcome Improvement Target 3 [IT-5.3]** Using identified subset population from process milestone 3 attempt to reduce or maintain ALOS for admissions compared to baseline
  - **Data Source:** EPIC Medical Record, Enterprise Data Warehouse
  - **Outcome Improvement Target 3 Estimated Incentive Payment**: $117,549

**Year 5** (10/1/2015 – 9/30/2016)

- **Outcome Improvement Target 3 [IT-5.3]** Using identified subset population from process milestone 3 attempt to reduce or maintain ALOS for admissions compared to baseline
  - **Data Source:** EPIC Medical Record, Enterprise Data Warehouse
  - **Outcome Improvement Target 3 Estimated Incentive Payment**: $281,095.50
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>Cost of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Texas Children’s Hospital</strong></td>
<td><strong>139135109</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>Cost of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TBD in DY 3</strong></td>
<td><strong>139135109.1.8</strong></td>
</tr>
</tbody>
</table>

**Year 2 (10/1/2012 – 9/30/2013):**
- Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $63,198.50

**Year 3 (10/1/2013 – 9/30/2014):**
- Year 3 Estimated Outcome Amount: $73,255

**Year 4 (10/1/2014 – 9/30/2015):**
- Year 4 Estimated Outcome Amount: $117,549

**Year 5 (10/1/2015 – 9/30/2016):**
- Year 5 Estimated Outcome Amount: $281,095.50

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $535,098
Title of Outcome Measure (Improvement Target): OD-10 Quality Of Life/ Functional Status
IT-10.1 Quality of Life

Unique RHP outcome identification number: 139135109.3.25/Texas Children’s Hospital

Outcome Measure Description:
OD-10 Quality Of Life/ Functional Status
IT-10.1 Quality of Life

Process milestone:
  DY 2 P-1; P-3
  DY3 P-4; P-5

Outcome Improvement Targets for each year:
  DY 4 IT- Increase patient visits by 5% from baseline
  DY 5 IT- Increase patient visits by 10% from baseline

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor patient access for the specific population within Texas Children’s Hospital system. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

Child abuse has long term effects for the child including psychological and somatic symptoms, as well as psychiatric and medical diagnoses. The Adverse Childhood Experiences (ACE) Study conducted in collaboration between the Center for Disease Control and Kaiser Permanente in San Diego, CA, is one of the largest investigations to look at the relationship between child maltreatment and long term effects. The study found a strong relationship between the level of traumatic stress in childhood and poor physical, mental and behavioral outcomes later in life. The identification and intervention by child abuse abuse pediatricians and supporting staff can be crucial to the child’s well being and the prevention of further abuse. Ensuring an accurate diagnosis of child abuse, appropriate treatment and follow-up care has direct impact on the child’s quality of life.

Given the limited availability of Child Abuse Pediatricians, loss of providers could prevent TCH from reaching target as replacement providers often take multiple years to recruit.

---

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.

---


### Quality of Life

**Texas Children’s Hospital**

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>139135109.1.9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>TBD in DY 3</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1] Project Planning</strong> – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 3 [P-4] Establish baseline via PDSA or other QI effort regarding patient referral and assessment by child abuse fellow</strong></td>
<td><strong>Outcome Improvement Target IT-10.1 Quality of Life</strong> a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population. Improvement Target: 24 patients Data source: PedsQL, Child Abuse Database/Registry</td>
<td><strong>Outcome Improvement Target IT-10.1 Quality of Life</strong> a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population. Improvement Target: 24 patients Data source: PedsQL, Child Abuse Database/Registry</td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td>Data Source: Advanced Quality Improvement (AQI) projects, Epic, Enterprise Data Warehouse, Rounding and multidisciplinary rounds</td>
<td>Estimated Incentive Payment: $109,546</td>
<td>Estimated Incentive Payment: $261,958</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $29,448</td>
<td>Process Milestone 3 Estimated Incentive Payment: $34,134</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]: Test Data System</strong></td>
<td><strong>Process Milestone 4 [P-5]:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td>Data Source: Reports and participation in learning collaboratives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $29,448</td>
<td>Process Milestone 4 Estimated Incentive Payment: $34,134</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>139135109.1.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $58,896</td>
<td>Year 3 Estimated Outcome Amount: $68,268</td>
<td>Year 4 Estimated Outcome Amount: $109,546</td>
<td>Year 5 Estimated Outcome Amount: $261,958</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $498,668*
Title of Outcome Measure (Improvement Target): OD- 10 Quality of Life/ Functional Status

Unique RHP outcome identification number: 139135109.3.26/Texas Children’s Hospital

Outcome Measure Description:
OD- 10 Quality of Life/ Functional Status
IT-10.1 Quality of Life

Process milestone:
   DY 2 P-1; P-3
   DY3 P-4; P-5

Outcome Improvement Targets for each year:
   DY 4 IT-10.1
   DY 5 IT- 10.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the quality of life for the specific population of Developmental Pediatrics within Texas Children’s Hospital system. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. Given the national shortage of Developmental Pediatricians, loss of providers could prevent TCH from reaching target as replacement providers often take multiple years to recruit.

Measuring Quality of Life metrics enables providers and patient families to better dialogue and improve health care delivery. Analyzing these QALY measures, empowers the health care community to develop new strategies about how children of diverse abilities are served and to improve multidisciplinary health care teams communication regarding a patient. Likewise, measuring QALY’s provides a useful tool for parents, siblings and other family that care for and nurture this child/patient such as information on expected developmental, physical and emotional outcomes. This information can be used to spur more dialogue with family and their providers regarding care decisions or challenges in care compliance and how to successfully resolve these issues in a coordinated agreed upon manner.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an

increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>139135109.1,10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td><strong>TBD in DY 3</strong></td>
</tr>
</tbody>
</table>
| **Year 2**<br>(10/1/2012 – 9/30/2013) | Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.  
  Data Source: EHR/Business Intelligence  
  Process Milestone 1 Estimated Incentive Payment (*maximum amount*): $49,008.50 |
| **Year 3**<br>(10/1/2013 – 9/30/2014) | Process Milestone 3 [P-4] Conduct PDSA or other QI effort assessing patient referral to specified service or lab to ensure communication and care coordination and improve efficiencies or identify deficiencies in various aspects of services.  
  **Data Source:** Advanced Quality Improvement (AQI) projects, Epic, Enterprise Data Warehouse, Rounding and multidisciplinary rounds  
  Process Milestone 3 Estimated Incentive Payment: $56,807 |
| **Year 4**<br>(10/1/2014 – 9/30/2015) | **Outcome Improvement Target IT-10.1 Quality of Life**  
a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.  
  Improvement Target: TBD by quality and clinical care team as QOL are reviewed for new population of patients  
  Improvement Target: TBD by quality and clinical care team as QOL are reviewed for new population of patients  
  **Data Source:** AQI projects, EPIC, Enterprise Data Warehouse  
  Estimated Incentive Payment: $182,311 |
| **Year 5**<br>(10/1/2015 – 9/30/2016) | **Outcome Improvement Target IT-10.1 Quality of Life**  
a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.  
  Improvement Target: TBD by quality and clinical care team as QOL are reviewed for new population of patients  
  Improvement Target: TBD by quality and clinical care team as QOL are reviewed for new population of patients  
  **Data Source:** AQI projects, EPIC, Enterprise Data Warehouse  
  Estimated Incentive Payment: $435,961 |
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Quality of Life</th>
<th>139135109.1.10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
<td>TBD in DY 3</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $98,017</td>
<td>Year 3 Estimated Outcome Amount: $113,614</td>
<td>Year 4 Estimated Outcome Amount: $182,311</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $829,903*
**Title of Outcome Measure (Improvement Target):** OD-5: Cost of Care

**Unique RHP outcome identification number:** 139135109.3.27/Texas Children’s Hospital

**Outcome Measure Description:**
OD-5: Cost of Care
IT-5.1 Improved cost savings: Cost Effectiveness

**Process milestone:**
- DY 2 P-1; P-3
- DY 3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT-5.1
- DY 5 IT-5.1

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY 4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY 3. The baseline costs, whether high or low, will dictate an appropriate improvement target goal.

“The central purpose of cost-effectiveness analysis (CEA) is to compare the costs and the values of different health care interventions in creating better health and longer life. Many new medical devices, procedures, diagnostic tests, and prescription drugs are expensive; cost-effectiveness analysis can help to evaluate whether the improvement in health care outcomes justifies the expenditures relative to other choices.” (Focus on Cost-Effectiveness Analysis at AHRQ: Fact Sheet. August 2001. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/findings/factsheets/costeff.html)

Cost effectiveness studies empower policy makers, hospital administrators, care providers and patients in prioritizing where finite health care dollars should be spent and what evidence-based protocols, medicines, technology and equipment should be combined in response to a population’s most compelling health need. In our project, this population is chronically ill children.

We hope to utilize the Center for Clinic Effectiveness at Baylor College of Medicine and Texas Children’s Hospital in coordinating many of our quality studies for the Waiver. Specifically, the Center is developing “score cards” of various chronic disease care models to improve our patient-centered care resources. The goal is to establish evidence-based, structured approaches to
various clinical procedures while simultaneously reducing variation in clinical practice and improve clinical and health outcomes.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.² The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---


<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>139135109.1.11</th>
<th>Cost of Care</th>
<th>139135109</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
<td>TBD in DY 3</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
<tr>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic on an allergy/immunology process, procedure or test to improve efficiencies and subsequently costs. Data Source: Advanced Quality Improvement (AQI) projects, Epic, Data Warehouse, physician and clinical time studies or time cards, facility costs.</td>
<td>Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: Cost Effectiveness of allergy/immunology procedures as determined by PDSA in DY 3 Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)</td>
<td>Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: Cost Effectiveness of allergy/immunology procedures as determined by PDSA in DY 3 Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)</td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td>Process Milestone 3 Estimated Incentive Payment: $15,793.75</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $50,686.75</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $121,207</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $13,625.50</td>
<td>Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Process Milestone 4 Estimated Incentive Payment: $15,793.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]: Test Data System</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $13,625.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>139135109.1.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $27,251</td>
<td>Year 3 Estimated Outcome Amount: $31,587.50</td>
<td>Year 4 Estimated Outcome Amount: $50,686.75</td>
<td>Year 5 Estimated Outcome Amount: $121,207</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $230,732.25*
Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.28/Texas Children’s Hospital

Outcome Measure Description:
OD-5: Cost of Care
IT-5.2 Per Episode of Care

Process milestone:
DY 2 P-1; P-3
DY 3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.2;
DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline costs, whether high or low, will dictate an appropriate improvement target goal.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

We agree with the TX HHSC DSRIP project’s goals of this waiver specific to cost of care. Our project will strive to develop better and more robust cost-of-care measures to help those who receive care, provide care and pay for care understand how pediatric providers, especially, pediatric subspecialists, use resources and compare these costs to local, regional or national benchmarks when available.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year

(“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic</td>
<td>Outcome Improvement Target 2 [IT-5.2] Per episode cost of care Improvement Target: Determine cost of episode of care for high volume or high complexity service such as lupus</td>
<td>Outcome Improvement Target 2 [IT-5.2] Per episode cost of care Improvement Target: Determine cost of episode of care for high volume or high complexity service such as lupus</td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td>Data Source: Advanced Quality Improvement (AQI) projects</td>
<td>a. Numerator: total cost for episode of care</td>
<td>a. Numerator: total cost for episode of care</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $13,625.50</td>
<td>Process Milestone 3 Estimated Incentive Payment: $15,793.75</td>
<td>b. Denominator: total number of episodes in one month/year</td>
<td>b. Denominator: total number of episodes in one month/year</td>
</tr>
<tr>
<td>Process Milestone 2 [P-3]: Test Data System</td>
<td>Process Milestone 4 Estimated Incentive Payment: $15,793.75</td>
<td>c. Data Source: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system)</td>
<td>c. Data Source: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system)</td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $50,686.75</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $15,793.75</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $121,207</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $13,625.50</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYS 2-5): $230,732.25

**Regional Healthcare Partnership Plan**

**Region 3**
Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.29/Texas Children’s Hospital

Outcome Measure Description:
OD-5: Cost of Care
IT-5.3 Length of Stay

Process milestone:
DY 2 P-1; P-3
DY 3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.3;
DY 5 IT-5.3

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

We have specifically identified reduction in Length of Stay as one of our quality outcomes as this measure has the highest resource consumption for a patient (barring any complications due to comorbidities or severity of illness). We hope to demonstrate that a reduction in length of stay allows for a better use of existing resources and hospital capacity, thus enabling us to serve more patients in less time currently required. Ultimately, this not only improves costs but also patient satisfaction in the care provided. Because we are caring for children, this is of utmost importance – to not keep the child away from his or her home for any unnecessary length of time due to inefficiencies in care delivery and coordination of discharge.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.² The QALY is

used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
| Process Milestone 1 [P-1] Project Planning | Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic to determine the subpopulation of Allergy and Immunology patients with the greatest opportunity for LOS reduction to establish a baseline |
| Data Source: EHR/Business Intelligence |
| Process Milestone 1 Estimated Incentive Payment (maximum amount): $13,625.50 |

| Process Milestone 2 [P-3]: Test Data System | Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders |
| Data Source: Enterprise Data Warehouse reports |
| Process Milestone 2 Estimated Incentive Payment: $13,625.50 |

| Outcome Improvement Target 3 [IT-5.3] Using identified subset population from process milestone 3 attempt to reduce or maintain ALOS for admissions compared to baseline |
| Data Source: EPIC Medical Record, Enterprise Data Warehouse |
| Outcome Improvement Target 3 Estimated Incentive Payment: $50,686.75 |

| Outcome Improvement Target 3 [IT-5.3] Using identified subset population from process milestone 3 attempt to reduce or maintain ALOS for admissions compared to baseline |
| Data Source: EPIC Medical Record, Enterprise Data Warehouse |
| Outcome Improvement Target 3 Estimated Incentive Payment: $121,207 |

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $13,625.50</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $15,793.75</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 4 Estimated Incentive Payment: $15,793.75</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome Improvement Target 3 Estimated Incentive Payment: $50,686.75</td>
</tr>
</tbody>
</table>

<p>| Outcome Improvement Target 3 Estimated Incentive Payment: $121,207 |</p>
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>139135109.1.11</th>
<th>Cost of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
<td>139135109</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $27,251</td>
<td>Year 3 Estimated Outcome Amount: $31,587.50</td>
<td>Year 4 Estimated Outcome Amount: $50,686.75</td>
<td>Year 5 Estimated Outcome Amount: $121,207</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $230,732.25*
Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.30/Texas Children’s Hospital

Outcome Measure Description:
OD-5: Cost of Care
IT-5.1 Improved cost savings:

Process milestone:
  DY 2 P-1; P-3
  DY 3 P-4; P-5

Outcome Improvement Targets for each year:
  DY 4 IT-5.1
  DY 5 IT-5.1

Rationale:
Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY 4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY 3. The baseline cost, whether high or low, will dictate an appropriate improvement target goal.

“The central purpose of cost-effectiveness analysis (CEA) is to compare the costs and the values of different health care interventions in creating better health and longer life. Many new medical devices, procedures, diagnostic tests, and prescription drugs are expensive; cost-effectiveness analysis can help to evaluate whether the improvement in health care outcomes justifies the expenditures relative to other choices.” (Focus on Cost-Effectiveness Analysis at AHRQ: Fact Sheet. August 2001. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/findings/factsheets/costeff.html)

Cost effectiveness studies empower policy makers, hospital administrators, care providers and patients in prioritizing where finite health care dollars should be spent and what evidence-based protocols, medicines, technology and equipment should be combined in response to a population’s most compelling health need. In our project, this population is chronically ill children.

We hope to utilize the Center for Clinic Effectiveness at Baylor College of Medicine and Texas Children’s Hospital in coordinating many of our quality studies for the Waiver. Specifically, the Center is developing “score cards” of various chronic disease care models to improve our patient-centered care resources. The goal is to establish evidence-based, structured approaches to
various clinical procedures while simultaneously reducing variation in clinical practice and improve clinical and health outcomes.

We recognize that while we are increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---


<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>139135109.1.12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>TBD in DY 3</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1] Project Planning</strong> – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic</strong> Data Source: Advanced Quality Improvement (AQI) projects</td>
<td><strong>Outcome Improvement Target 1 [IT-5.1] Improved cost savings:</strong> Demonstrate cost savings in care delivery Improvement Target: Cost Effectiveness of Otolaryngology surgical procedures Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)</td>
<td><strong>Outcome Improvement Target 1 [IT-5.1] Improved cost savings:</strong> Demonstrate cost savings in care delivery Improvement Target: Cost Effectiveness of Otolaryngology surgical procedures Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)</td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td>Process Milestone 3 Estimated Incentive Payment: $16,343</td>
<td><strong>Outcome Improvement Target 1 [IT-5.1] Estimated Incentive Payment:</strong> $52,449.25</td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong> $125,422</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $14,099.25</td>
<td><strong>Process Milestone 4 [P-5]:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives</td>
<td><strong>Process Milestone 4 Estimated Incentive Payment:</strong> $16,343</td>
<td><strong>Process Milestone 4 Estimated Incentive Payment:</strong> $125,422</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]: Test Data System</strong> Data Source: Enterprise Data Warehouse reports</td>
<td><strong>Process Milestone 4 Estimated Incentive Payment:</strong> $16,343</td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong> $52,449.25</td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong> $125,422</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $14,099.25</td>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $28,198.50</td>
<td>Year 3 Estimated Outcome Amount: $32,686</td>
<td>Year 4 Estimated Outcome Amount: $52,449.25</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong></td>
<td><strong>Year 3 Estimated Outcome Amount:</strong></td>
<td><strong>Year 4 Estimated Outcome Amount:</strong></td>
<td><strong>Year 5 Estimated Outcome Amount:</strong></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add outcome amounts over DYs 2-5): $238,755.75</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong></td>
<td><strong>Year 5 Estimated Outcome Amount:</strong></td>
<td><strong>Year 5 Estimated Outcome Amount:</strong></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add outcome amounts over DYs 2-5): $238,755.75</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong></td>
<td><strong>Year 5 Estimated Outcome Amount:</strong></td>
<td><strong>Year 5 Estimated Outcome Amount:</strong></td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.31/Texas Children’s Hospital

Outcome Measure Description:
OD-5: Cost of Care
IT-5.2 Per Episode of Care

Process milestone:
DY 2 P-1; P-3
DY 3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.2
DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY 4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY 3. The baseline cost, whether high or low, will dictate an appropriate improvement target goal. We agree with the TX HHSC DSRIP project’s goals of this waiver specific to cost of care. Our project will strive to develop better and more robust cost-of-care measures to help those who receive care, provide care and pay for care understand how pediatric providers, especially, pediatric subspecialists, use resources and compare these costs to local, regional or national benchmarks when available.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year

---

(“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>139135109.1.12</th>
<th>Cost of Care (per episode of care)</th>
<th>139135109</th>
</tr>
</thead>
</table>

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1 [P-1] Project Planning** – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- Data Source: EHR/Business Intelligence

- Process Milestone 1 Estimated Incentive Payment (*maximum amount*): $14,099.25

**Process Milestone 2 [P-3]: Test Data System**

- Data Source: Enterprise Data Warehouse reports

- Process Milestone 2 Estimated Incentive Payment: $14,099.25

**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic**

- Data Source: Advanced Quality Improvement (AQI) projects

- Process Milestone 3 Estimated Incentive Payment: $16,343

**Process Milestone 4 [P-5]:**

- Disseminate findings, including lessons learned and best practices, to stakeholders

- Data Source: Reports and participation in learning collaboratives

- Process Milestone 4 Estimated Incentive Payment: $16,343

**Outcome Improvement Target 2 [IT-5.2]**

- Per episode cost of care

- Improvement Target: Determine cost of episode of care for high volume or high complexity surgical service

- a. Numerator: total cost for episode of care

- b. Denominator: total number of episodes in one month/year

- c. Data Source: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system)

- Outcome Improvement Target 2 Estimated Incentive Payment: $52,449.25

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**

- (*add outcome amounts over DYs 2-5*): $238,755.75

---

Regional Healthcare Partnership Plan

Region 3
Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.32/Texas Children’s Hospital

Outcome Measure Description:
IT-5.3 (Other Outcome Improvement Target) Reduce Unplanned Re-operations

Process milestone:

DY 2 P-1; P-3
DY 3 P-4; P-5

Outcome Improvement Targets for each year:

DY 4 IT-5.3
DY 5 IT-5.3

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. We agree that increased access should be coupled with controlling unnecessary costs especially, if these costs are associated with an unplanned reoperation of a child.

The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has suggested that unplanned reoperations could be tracked as a “screening tool” for quality assurance. A current research article published by a team of surgeons at Dartmouth-Hitchcock Medical Center, the Veteran’s Affairs Quality Group, the department of Surgery at Dartmouth Medical School and the Department of Veteran Affairs entitled, “Is Unplanned Return to the Operating Room a Useful Quality Indicator in General Surgery?” recommends that unplanned reoperations have important implications for patients – not only their health outcomes but also their safety and overall satisfaction with the care they receive. Regarding patient safety, an unplanned reoperation may result in a higher mortality and, “… certain patient-related and procedure-related factors increase risk.”

In the research, it was acknowledged that unplanned surgeries are obviously, not the choice of a patient or family member and that such events are usually isolated incidents. However, as a leader in providing regional access to tertiary and quaternary services to children, we must constantly strive to provide care that is effective and safe. As we measure our access to
subspecialty surgical services, we hope to establish quality of care models for our pediatric patients that provide a high rate of return. We believe that tracking unplanned reoperations will greatly assist us in these efforts.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.² The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---


### Related Category 1 or 2 Projects:

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>Cost of Care Reduce Unplanned Reoperations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Texas Children’s Hospital 139135109.1.12</td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>TBD in DY 3</td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td></td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
</tbody>
</table>

#### Process Milestone 1 [P-1]: Project Planning
- Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- Data Source: EHR/Business Intelligence
- Process Milestone 1 Estimated Incentive Payment *(maximum amount)*: $14,099.25

#### Process Milestone 2 [P-3]: Test Data System
- Data Source: Enterprise Data Warehouse reports
- Process Milestone 2 Estimated Incentive Payment: $14,099.25

#### Process Milestone 3 [P-4]: Conduct PDSA by subspecialty clinic
- Data Source: Advanced Quality Improvement (AQI) projects
- Process Milestone 3 Estimated Incentive Payment: $16,343

#### Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders
- Data Source: Reports and participation in learning collaboratives
- Process Milestone 4 Estimated Incentive Payment: $16,343

#### Outcome Improvement Target 3 [IT-5.3]: Reduce Unplanned Reoperations
- Improvement Target: Track and/or reduce unplanned re-operations
- Improvement Target: Determine a specific high acuity or high complexity procedure that required re-operation and design a clinical and quality course of action to prevent, not increase or reduce this outcome over time.
- Numerator: # of unplanned reoperations identified by acuity or complexity
- Denominator: Total # of operations by identified high acuity or high complexity procedure
- Data Source: EPIC Medical Record Enterprise Data Warehouse (contains clinical and financial data for integrated system), database created by newly hired Outcomes research nurse.
- Outcome Improvement Target 3 Estimated Incentive Payment: $52,449.25

#### Outcome Improvement Target 3 [IT-5.3] Reduce Unplanned Reoperations
- Improvement Target: Reduce unplanned re-operation
- Improvement Target: determine a specific high acuity or high complexity procedure that required re-operation and design a clinical and quality course of action to prevent or reduce this outcome
- Numerator: # of unplanned reoperations identified by acuity or complexity
- Denominator: Total # of operations by identified high acuity or high complexity procedure
- Data Source: EPIC Medical Record Enterprise Data Warehouse (contains clinical and financial data for integrated system), database created by newly hired Outcomes research nurse.
- Outcome Improvement Target 3 Estimated Incentive Payment: $125,422
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>139135109.1.12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td></td>
</tr>
<tr>
<td>(add incentive payments amounts</td>
<td></td>
</tr>
<tr>
<td>from each milestone/outcome</td>
<td></td>
</tr>
<tr>
<td>improvement target): $28,198.50</td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount:</td>
<td>$32,686</td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td></td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount:</td>
<td>$52,449.25</td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount:</td>
<td>$125,422</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $238,755.75
Title of Outcome Measure (Improvement Target): O-D5: Cost of Care

Unique RHP outcome identification number: 139135109.3.33/Texas Children’s Hospital

Outcome Measure Description: OD-5: Cost of Care
   IT-5.1 Improved cost savings

Process milestone:
   DY 2 P-1; P-3
   DY3 P-4; P-5

Outcome Improvement Targets for each year:
   DY 4 IT-5.1;
   DY 5 IT-5.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, and there is only a finite amount of money to fund critical programs. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet these same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.² The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Cost of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Texas Children’s Hospital</strong></td>
<td>139135109</td>
</tr>
</tbody>
</table>

Starting Point/Baseline: TBD in DY 3

### Year 2 (10/1/2012 – 9/30/2013)

**Process Milestone 1 [P-1] Project Planning** – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- Data Source: EHR/Business Intelligence
- Process Milestone 1 Estimated Incentive Payment (maximum amount): $20,239.25

**Process Milestone 2 [P-3]: Test Data System**
- Data Source: Enterprise Data Warehouse reports
- Process Milestone 2 Estimated Incentive Payment: $20,239.25

### Year 3 (10/1/2013 – 9/30/2014)

**Process Milestone 3 [P-4]:** Conduct PDSA by subspecialty clinic
- Data Source: Advanced Quality Improvement (AQI) projects
- Process Milestone 3 Estimated Incentive Payment: $23,460

**Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders
- Data Source: Reports and participation in learning collaboratives
- Process Milestone 4 Estimated Incentive Payment: $23,460

**Outcome Improvement Target 1 [IT-5.1]:** Improved cost savings: Demonstrate cost savings in care delivery
- Improvement Target: Cost Effectiveness of Plastic surgical procedures
- Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)
- Process Milestone 4 Estimated Incentive Payment: $75,290.25

### Year 4 (10/1/2014 – 9/30/2015)

**Outcome Improvement Target 1 [IT-5.1]:** Improved cost savings: Demonstrate cost savings in care delivery
- Improvement Target: Cost Effectiveness of Plastic surgical procedures
- Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)
- Process Milestone 4 Estimated Incentive Payment: $180,041.50

### Year 5 (10/1/2015 – 9/30/2016)

**Outcome Improvement Target 1 [IT-5.1]:** Improved cost savings: Demonstrate cost savings in care delivery
- Improvement Target: Cost Effectiveness of Plastic surgical procedures
- Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system)
- Process Milestone 4 Estimated Incentive Payment: $180,041.50

### Outcome Improvement Target 1 Estimated Incentive Payment:
- Year 2: $20,239.25
- Year 3: $75,290.25
- Year 4: $180,041.50

### TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD
(add outcome amounts over DYs 2-5): $342,730.25

Regional Healthcare Partnership Plan
Region 3
Title of Outcome Measure (Improvement Target): O-D5: Cost of Care

Unique RHP outcome identification number: 139135109.3.34/Texas Children’s Hospital

Outcome Measure Description: OD-5: Cost of Care
   IT-5.2 Per Episode of Care

Process milestone:
   DY 2 P-1; P-3
   DY3 P-4; P-5

Outcome Improvement Targets for each year:
   DY 4 IT-5.2
   DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline cost, whether high or low, will dictate an appropriate improvement target goal. We agree with the TX HHSC DSRIP project’s goals of this waiver specific to cost of care. Our project will strive to develop better and more robust cost-of-care measures to help those who receive care, provide care and pay for care understand how pediatric providers, especially, pediatric subspecialists, use resources and compare these costs to local, regional or national benchmarks when available.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, and there is only a finite amount of money to fund critical programs. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet these same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. ¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year

(“QALY”) per year and a percentage of that QALY for the pediatric population.² The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>139135109.1.13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1] Project Planning</strong> – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence</td>
<td><strong>Process Milestone 3 [P-4]</strong> Conduct PDSA by subspecialty clinic Data Source: Advanced Quality Improvement (AQI) projects</td>
<td><strong>Process Milestone 3 Estimated Incentive Payment:</strong> $23,460</td>
<td><strong>Outcome Improvement Target 2 [IT-5.2]</strong> Per episode cost of care Improvement Target: Determine cost of episode of care for high volume or high complexity surgical service a. Numerator: total cost for episode of care b. Denominator: total number of episodes in one month/year c. Data Source: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system)</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]: Test Data System</strong> Data Source: Enterprise Data Warehouse reports</td>
<td><strong>Process Milestone 4 [P-5]:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives</td>
<td><strong>Process Milestone 4 Estimated Incentive Payment:</strong> $23,460</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $75,290.25</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> (add incentive payments amounts from each milestone/outcome improvement target): $40,478.50</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $46,920</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $75,290.25</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $180,041.50</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $342,730.25
**Title of Outcome Measure (Improvement Target):** OD-5: Cost of Care

**Unique RHP outcome identification number:** 139135109.3.35/Texas Children’s Hospital

**Outcome Measure Description:** OD-5: Cost of Care
IT-5.3 (Other Outcome Improvement Target) Reduce Unplanned Re-operations

**Process milestone:**
- DY 2 P-1; P-3
- DY 3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT-5.3
- DY 5 IT-5.3

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY 4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY 3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, and there is only a finite amount of money to fund critical programs. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. We agree that increased access should be coupled with controlling unnecessary costs especially, if these costs are associated with an unplanned reoperation of a child.

The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has suggested that unplanned reoperations could be tracked as a “screening tool” for quality assurance. A current research article published by a team of surgeons at Dartmouth-Hitchcock Medical Center, the Veteran’s Affairs Quality Group, the department of Surgery at Dartmouth Medical School and the Department of Veteran Affairs entitled, “Is Unplanned Return to the Operating Room a Useful Quality Indicator in General Surgery?” recommends that unplanned reoperations have important implications for patients – not only their health outcomes but also their safety and overall satisfaction with the care they receive. Regarding patient safety, an unplanned reoperation may result in a higher mortality and, “… certain patient-related and procedure-related factors increase risk.”

In the research, it was acknowledged that unplanned surgeries are obviously, not the choice of a patient or family member and that such events are usually isolated incidents. However, as a leader in providing regional access to tertiary and quaternary services to children, we must constantly strive to provide care that is effective and safe. As we measure our access to subspecialty
surgical services, we hope to establish quality of care models for our pediatric patients that provide a high rate of return. We believe that tracking unplanned reoperations will greatly assist us in these efforts.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>139135109.1.13</th>
<th>Cost of Care Reduce Unplanned Reoperations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Texas Children’s Hospital</strong></td>
<td>139135109</td>
<td></td>
</tr>
</tbody>
</table>

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1 [P-1] Project Planning** – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- Data Source: EHR/Business Intelligence

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $20,239.25

**Process Milestone 2 [P-3]: Test Data System**

- Data Source: Enterprise Data Warehouse reports

**Process Milestone 2 Estimated Incentive Payment:** $20,239.25

**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic**

- Data Source: Advanced Quality Improvement (AQI) projects

**Process Milestone 3 Estimated Incentive Payment:** $23,460

**Process Milestone 4 [P-5]:**

- Disseminate findings, including lessons learned and best practices, to stakeholders

- Data Source: Reports and participation in learning collaboratives

**Process Milestone 4 Estimated Incentive Payment:** $23,460

**Outcome Improvement Target 3 [IT-5.3] Reduce Unplanned Reoperations**

- Improvement Target: Track and/or reduce unplanned re-operations

- Improvement Target: Determine a specific high acuity or high complexity procedure that required re-operation and design a clinical and quality course of action to prevent, not increase or reduce this outcome over time.

- Numerator: # of unplanned reoperations identified by acuity or complexity

- Denominator: Total # of operations by identified high acuity or high complexity procedure

- Data Source: EPIC Medical Record Enterprise Data Warehouse (contains clinical and financial data for integrated system), database created by newly hired Outcomes research nurse.

**Outcome Improvement Target 3 Estimated Incentive Payment:** $75,290.25

**Outcome Improvement Target 3 [IT-5.3] Reduce Unplanned Reoperations**

- Improvement Target: Reduce unplanned re-operation

- Improvement Target: determine a specific high acuity or high complexity procedure that required re-operation and design a clinical and quality course of action to prevent or reduce this outcome

- Numerator: # of unplanned reoperations identified by acuity or complexity

- Denominator: Total # of operations by identified high acuity or high complexity procedure

- Data Source: EPIC Medical Record Enterprise Data Warehouse (contains clinical and financial data for integrated system), database created by newly hired Outcomes research nurse.

**Outcome Improvement Target 3 Estimated Incentive Payment:** $180,041.50
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects::</th>
<th>139135109.1.13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $40,478.50</td>
<td>Year 3 Estimated Outcome Amount: $46,920</td>
<td>Year 4 Estimated Outcome Amount: $75,290.25</td>
<td>Year 5 Estimated Outcome Amount: $180,041.50</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $342,730.25
**Title of Outcome Measure (Improvement Target):** OD5-Cost of Care

**Unique RHP outcome identification number:** 139135109.3.36/Texas Children’s Hospital

**Outcome Measure Description:** Cost of Care

**IT-5.1 Improved cost savings:**

**Process milestone:**
- DY 2 P-1; P-3
- DY3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT-5.1;
- DY 5 IT-5.1

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.² The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.


<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans <strong>Data Source:</strong> EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment (maximum amount): $9646</td>
<td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic <strong>Data Source:</strong> Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: $11,181</td>
<td>Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: Cost Effectiveness of Neurosurgery procedures <strong>Data Source:</strong> EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system) Outcome Improvement Target 1 Estimated Incentive Payment: $35883</td>
<td>Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: Cost Effectiveness of Neurosurgery procedures <strong>Data Source:</strong> EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system) Outcome Improvement Target 1 Estimated Incentive Payment: $85807</td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]: Test Data System</strong> <strong>Data Source:</strong> Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $9646</td>
<td><strong>Process Milestone 4 [P-5]:</strong> Disseminate findings, including lessons learned and best practices, to stakeholders <strong>Data Source:</strong> Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment: $11,181</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $19292</td>
<td>Year 3 Estimated Outcome Amount: $22,362</td>
<td>Year 4 Estimated Outcome Amount: $35883</td>
<td>Year 5 Estimated Outcome Amount: $85807</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $163,344
Title of Outcome Measure (Improvement Target): OD5-Cost of Care

Unique RHP outcome identification number: 139135109.3.37/Texas Children’s Hospital

Outcome Measure Description: Cost of Care

IT-5.2 Per Episode of Care:

Process milestone:
- DY 2 P-1; P-3
- DY3 P-4; P-5

Outcome Improvement Targets for each year:
- DY 4 IT-5.2;
- DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline costs, whether high or low, will dictate an appropriate improvement target goal. We agree with the TX HHSC DSRIP project’s goals of this waiver specific to cost of care. Our project will strive to develop better and more robust cost-of-care measures to help those who receive care, provide care and pay for care understand how pediatric providers, especially, pediatric subspecialists, use resources and compare these costs to local, regional or national benchmarks when available.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality


of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>139135109.1,14</th>
<th>Cost of Care</th>
<th>139135109</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
<td>Texas Children’s Hospital</td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $9646</td>
<td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic Improvement (AQI) projects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $11,181</td>
<td>Outcome Improvement Target 2 [IT-5.2] Per episode cost of care Improvement Target: Determine cost of episode of care for high volume or high complexity surgical service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>a. Numerator: total cost for episode of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Reports and participation in learning collaboratives</td>
<td>b. Denominator: total number of episodes in one month/year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 4 Estimated Incentive Payment: $11,181</td>
<td>c. Data Source: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 [P-3]: Test Data System</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $35883</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td></td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $85807</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $9646</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $19,292</td>
<td>Year 3 Estimated Outcome Amount: $22,362</td>
<td>Year 4 Estimated Outcome Amount: $35883</td>
<td>Year 5 Estimated Outcome Amount: $85807</td>
</tr>
<tr>
<td>Total Estimated Incentive Payments for 4-Year Period (add outcome amounts over DYs 2-5): $163,344</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): OD5-Cost of Care

Unique RHP outcome identification number: 139135109.3.38/Texas Children’s Hospital

Outcome Measure Description: Cost of Care
IT-5.3 (Other Outcome Improvement Target) Reduce Unplanned Re-operations

Process milestone:
- DY 2 P-1; P-3
- DY3 P-4; P-5

Outcome Improvement Targets for each year:
- DY 4 IT-5.3;
- DY 5 IT-5.3

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. We agree that increased access should be coupled with controlling unnecessary costs especially, if these costs are associated with an unplanned reoperation of a child.

The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has suggested that unplanned reoperations could be tracked as a “screening tool” for quality assurance. A current research article published by a team of surgeons at Dartmouth-Hitchcock Medical Center, the Veteran’s Affairs Quality Group, the department of Surgery at Dartmouth Medical School and the Department of Veteran Affairs entitled, “Is Unplanned Return to the Operating Room a Useful Quality Indicator in General Surgery?” recommends that unplanned reoperations have important implications for patients – not only their health outcomes but also their safety and overall satisfaction with the care they receive. Regarding patient safety, an unplanned reoperation may result in a higher mortality and, “… certain patient-related and procedure-related factors increase risk.”

In the research, it was acknowledged that unplanned surgeries are obviously, not the choice of a patient or family member and that such events are usually isolated incidents. However, as a leader in providing regional access to tertiary and quaternary services to children, we must constantly strive to provide care that is effective and safe. As we measure our access to subspecialty surgical services, we hope to establish quality of care models for our pediatric patients that
provide a high rate of return. We believe that tracking unplanned reoperations will greatly assist us in these efforts.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---


<table>
<thead>
<tr>
<th>Year</th>
<th>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Process Milestone 2 [P-3]: Test Data System</th>
<th>Process Milestone 3 [P-4]: Conduct PDSA by subspecialty clinic</th>
<th>Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders</th>
<th>Outcome Improvement Target 3 [IT-5.3] Reduce Unplanned Reoperations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td><strong>Starting Point/Baseline:</strong> TBD in DY 3</td>
<td><strong>Data Source:</strong> EHR/Business Intelligence</td>
<td><strong>Data Source:</strong> Reports and participation in learning collaboratives</td>
<td><strong>Data Source:</strong> Enterprise Data Warehouse reports</td>
<td><strong>Outcome Improvement Target 3 Estimated Incentive Payment:</strong> $35883</td>
</tr>
<tr>
<td>Year 3</td>
<td><strong>Outcome Improvement Target 3 [IT-5.3] Reduce Unplanned Reoperations</strong> Improvement Target: Track and/or reduce unplanned re-operations Improvement Target: Determine a specific high acuity or high complexity procedure that required re-operation and design a clinical and quality course of action to prevent, not increase or reduce this outcome over time. Numerator: # of unplanned reoperations identified by acuity or complexity Denominator: Total # of operations by identified high acuity or high complexity procedure</td>
<td><strong>Data Source:</strong> EPIC Medical Record Enterprise Data Warehouse (contains clinical and financial data for integrated system), database created by newly hired Outcomes research nurse.</td>
<td><strong>Data Source:</strong> EPIC Medical Record Enterprise Data Warehouse (contains clinical and financial data for integrated system), database created by newly hired Outcomes research nurse.</td>
<td><strong>Outcome Improvement Target 3 Estimated Incentive Payment:</strong> $85807</td>
<td></td>
</tr>
<tr>
<td>(10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Outcome Improvement Target 3 [IT-5.3] Reduce Unplanned Reoperations</strong> Improvement Target: Reduce unplanned re-operation Improvement Target: determine a specific high acuity or high complexity procedure that required re-operation and design a clinical and quality course of action to prevent or reduce this outcome Numerator: # of unplanned reoperations identified by acuity or complexity Denominator: Total # of operations by identified high acuity or high complexity procedure</td>
</tr>
<tr>
<td>(10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Outcome Improvement Target 3 [IT-5.3] Reduce Unplanned Reoperations</strong> Improvement Target: Reduce unplanned re-operation Improvement Target: determine a specific high acuity or high complexity procedure that required re-operation and design a clinical and quality course of action to prevent or reduce this outcome Numerator: # of unplanned reoperations identified by acuity or complexity Denominator: Total # of operations by identified high acuity or high complexity procedure</td>
</tr>
<tr>
<td>(10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>139135109.1.14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $19292</td>
<td>Year 3 Estimated Outcome Amount: $22,362</td>
<td>Year 4 Estimated Outcome Amount: $35883</td>
<td>Year 5 Estimated Outcome Amount: $85807</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $163,344*
Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.39/Texas Children’s Hospital

Outcome Measure Description: OD-5: Cost of Care
IT-5.1 Improved cost savings

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.1;
DY 5 IT-5.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is a only a finite about of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.² The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>139135109.1.15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>TBD in DY 3</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong> <em>(10/1/2012 – 9/30/2013)</em></td>
<td></td>
</tr>
</tbody>
</table>
| **Process Milestone 1 [P-1] Project Planning** – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
  Data Source: EHR/Business Intelligence |                             |
| Process Milestone 1 Estimated Incentive Payment *(maximum amount):* | $26,157 |
| **Process Milestone 2 [P-3]: Test Data System**  
  Data Source: Enterprise Data Warehouse reports |                             |
| Process Milestone 2 Estimated Incentive Payment: | $26,157 |
| **Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic**  
  Data Source: Advanced Quality Improvement (AQI) projects |                             |
| Process Milestone 3 Estimated Incentive Payment: | $30,319.25 |
| **Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders**  
  Data Source: Reports and participation in learning collaboratives |                             |
| Process Milestone 4 Estimated Incentive Payment: | $30,319.25 |
| **Outcome Improvement Target 1 [IT.5.1] Improved cost savings:** Demonstrate cost savings in care delivery  
  Improvement Target: Cost Effectiveness of Ophthalmology surgical procedures  
  Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system) |                             |
| Outcome Improvement Target 1 Estimated Incentive Payment: | $97,303.75 |
| **Outcome Improvement Target 1 [IT.5.1] Improved cost savings:** Demonstrate cost savings in care delivery  
  Improvement Target: Cost Effectiveness of Ophthalmology surgical procedures  
  Data Source: EPIC Medical Record, Enterprise Data Warehouse (includes clinical and financial data for integrated system) |                             |
| Outcome Improvement Target 1 Estimated Incentive Payment: | $57,683 |
| **Year 2 Estimated Outcome Amount:** (add incentive payments amounts from each milestone/outcome improvement target): | $52,314 |
| **Year 3** *(10/1/2013 – 9/30/2014)* |                             |
| **Year 3 Estimated Outcome Amount:** | $60,638.50 |
| **Year 4** *(10/1/2014 – 9/30/2015)* |                             |
| **Year 4 Estimated Outcome Amount:** | $97,303.75 |
| **Year 5** *(10/1/2015 – 9/30/2016)* |                             |
| **Year 5 Estimated Outcome Amount:** | $57,683 |
| **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* | $267,939 |
Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.40/Texas Children’s Hospital

Outcome Measure Description: OD-5: Cost of Care
   IT-5.2 Per Episode of Care

Process milestone:
   DY 2 P-1; P-3
   DY3 P-4; P-5

Outcome Improvement Targets for each year:
   DY 4 IT-5.2;
   DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline cost, whether high or low, will dictate an appropriate improvement target goal.

We agree with the TX HHSC DSRIP project’s goals of this waiver specific to cost of care. Our project will strive to develop better and more robust cost-of-care measures to help those who receive care, provide care and pay for care understand how pediatric providers, especially, pediatric subspecialists, use resources and compare these costs to local, regional or national benchmarks when available.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is a only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year

(“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 3</strong> [P-4]: Conduct PDSA by subspecialty clinic</td>
<td><strong>Outcome Improvement Target 2</strong> [IT-5.2] Per episode cost of care Improvement Target: Determine cost of episode of care for high volume or high complexity surgical service</td>
<td><strong>Outcome Improvement Target 2</strong> [IT-5.2] Per episode cost of care Improvement Target: Determine cost of episode of care for high volume or high complexity surgical service</td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td>Data Source: Advanced Quality Improvement (AQI) projects</td>
<td>a. Numerator: total cost for episode of care</td>
<td>a. Numerator: total cost for episode of care</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $26,157</td>
<td>Process Milestone 3 Estimated Incentive Payment: $30,319.25</td>
<td>b. Denominator: total number of episodes in one month/year</td>
<td>b. Denominator: total number of episodes in one month/year</td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong> [P-3]: Test Data System</td>
<td><strong>Process Milestone 4</strong> [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>c. Data Source: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system)</td>
<td>c. Data Source: EPIC Medical Record, Enterprise Data Warehouse (contains both clinical and financial data for integrated system)</td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td>Data Source: Reports and participation in learning collaboratives</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $97,303.75</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $57,683</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $26,157</td>
<td>Process Milestone 4 Estimated Incentive Payment: $30,319.25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Year 2 Estimated Outcome Amount:** (add incentive payments amounts from each milestone/outcome improvement target): $52,314  
**Year 3 Estimated Outcome Amount:** $60,638.50  
**Year 4 Estimated Outcome Amount:** $97,303.75  
**Year 5 Estimated Outcome Amount:** $57,683

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $267,939
**Title of Outcome Measure (Improvement Target):** OD-5: Cost of Care

**Unique RHP outcome identification number:** 139135109.3.41/Texas Children’s Hospital

**Outcome Measure Description:** OD-5: Cost of Care
IT-5.3 (Other Outcome Improvement Target) Reduce Unplanned Re-operations

**Process milestone:**
- DY 2 P-1; P-3
- DY3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT-5.3;
- DY 5 IT-5.3

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is a only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. We agree that increased access should be coupled with controlling unnecessary costs especially, if these costs are associated with an unplanned reoperation of a child.

The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has suggested that unplanned reoperations could be tracked as a “screening tool” for quality assurance. A current research article published by a team of surgeons at Dartmouth-Hitchcock Medical Center, the Veteran’s Affairs Quality Group, the department of Surgery at Dartmouth Medical School and the Department of Veteran Affairs entitled, “Is Unplanned Return to the Operating Room a Useful Quality Indicator in General Surgery?” recommends that unplanned reoperations have important implications for patients – not only their health outcomes but also their safety and overall satisfaction with the care they receive. Regarding patient safety, an unplanned reoperation may result in a higher mortality and, “… certain patient-related and procedure-related factors increase risk.”

In the research, it was acknowledged that unplanned surgeries are obviously, not the choice of a patient or family member and that such events are usually isolated incidents. However, as a leader in providing regional access to tertiary and quaternary services to children, we must constantly strive to provide care that is effective and safe. As we measure our access to subspecialty surgical services, we hope to establish quality of care models for our pediatric patients that
provide a high rate of return. We believe that tracking unplanned reoperations will greatly assist us in these efforts.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.² The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---


<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic</td>
<td>Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
<td>Outcome Improvement Target 3 [IT-5.3]: Reduce Unplanned Reoperations</td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td>Data Source: Advanced Quality Improvement (AQI) projects</td>
<td>Data Source: Reports and participation in learning collaboratives</td>
<td>Data Source: EPIC Medical Record Enterprise Data Warehouse (contains clinical and financial data for integrated system), database created by newly hired Outcomes research nurse.</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 [P-3]: Test Data System</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $26,157</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects::</td>
<td>139135109.1.15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td></td>
<td>----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY 3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>139135109.3.41</th>
<th>IT- 5.3</th>
<th>Cost of Care Reduce Unplanned Reoperations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Children’s Hospital</td>
<td>139135109</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $52,314</td>
<td>Year 3 Estimated Outcome Amount: $60,638.50</td>
<td>Year 4 Estimated Outcome Amount: $97,303.75</td>
<td>Year 5 Estimated Outcome Amount: $57,683</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $267,939
**Title of Outcome Measure (Improvement Target):** OD-10 Quality of Life/Functional Status;

**Unique RHP outcome identification number:** 139135109.3.42/Texas Children’s Hospital

**Outcome Measure Description:**
OD-10 Quality of Life/Functional Status

**IT-10.1 Quality of Life**

**Process milestone:**
- DY 2 P-1; P-3
- DY 3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT 1.1; IT 10.1
- DY 5 IT 1.1; IT 10.1

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the access to care and quality of life for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline third next available appointment and baseline initial score on the Edinburgh Postnatal Depression Scale for quality of life for this population. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline third next available metric is set in DY3. We will aim for a post-treatment score of 13 on the Edinburgh Postnatal Depression Scale as the improvement target for quality of life. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is an only a finite amount of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is

---


used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
<table>
<thead>
<tr>
<th>139135109.3.42</th>
<th>IT-10.1</th>
<th>Quality of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Texas Children’s Hospital</strong></td>
<td>139135109.1.16</td>
<td>139135109</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects::</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>TBD in DY 3</td>
<td></td>
</tr>
</tbody>
</table>

### Year 2 (10/1/2012 – 9/30/2013)

**Process Milestone 1 [P-1] Project Planning** – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- Data Source: EHR/Business Intelligence

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $15,797.25

**Process Milestone 2 [P-3]: Test Data System**

- Data Source: Enterprise Data Warehouse reports

**Process Milestone 2 Estimated Incentive Payment:** $15,797.25

### Year 3 (10/1/2013 – 9/30/2014)

**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic**

- Data Source: Advanced Quality Improvement (AQI) projects

**Process Milestone 3 Estimated Incentive Payment:** $18,313.75

**Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders

- Data Source: Reports and participation in learning collaboratives

**Process Milestone 4 Estimated Incentive Payment:** $18,313.75

### Year 4 (10/1/2014 – 9/30/2015)

**Outcome Improvement Target [IT 10.1] Quality of Life**

a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.

b. Data Source: Edinburgh Postnatal Depression Scale

**Goal:** Decrease score to 13 on EPDS tool upon discharge of treatment.

**Estimated Incentive Payment:** $58,774.50

### Year 5 (10/1/2015 – 9/30/2016)

**Outcome Improvement Target [IT 10.1] Quality of Life**

a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.

b. Data Source: Edinburgh Postnatal Depression Scale

**Goal:** Decrease score to 13 on EPDS tool upon discharge of treatment.

**Estimated Incentive Payment:** $140,547.50

### Year 2 Estimated Outcome Amount:

(Add incentive payments amounts from each milestone/outcome improvement target): $31,594.50

### Year 3 Estimated Outcome Amount:

$36,627.50

### Year 4 Estimated Outcome Amount:

$58,774.50

### Year 5 Estimated Outcome Amount:

$140,547.50

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (Add outcome amounts over DYs 2-5): $267,548.50
Title of Outcome Measure (Improvement Target): Patient Satisfaction

Unique RHP outcome identification number: 139135109.3.43/Texas Children’s Hospital

Outcome Measure Description: Patient Satisfaction
IT-6.1 Improved patient satisfaction

Process milestone:
DY 2 P-1; P-3
DY 3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-6.1
DY 5 IT-6.1

Rationale: Our project will increase appropriate access to patient centered coordinated care. Increased access to appropriate care leads to better long term outcomes in children and reduction in unnecessary health care costs.\(^1\) This population will still need to be hospitalized but we believe that through appropriate access and care coordination we will be able to reduce the cost of care.

Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

The value of this project can be measured with access, population management and overall quality of life. This initiative will dramatically impact the lives of 100% of the special needs population projected to be over 10,000 in greater Houston. The care coordination services include: medical, surgical, inpatient, outpatient, social economic, job placement, insurance counseling coverage, case management, social worker, educational training and engagement of local and national advocacy groups.

TCH engaged in a partnership with Press Ganey in late 2011. The surveys administered by Press Ganey are developed using accepted scientific methodology for survey design. The approach includes conducting focus groups of providers and administrators, reviewing surveys from health care facilities across the country, reviewing current professional and scientific publications on health care delivery, and utilizing the latest research on survey statistics and design. Press Ganey

allows us to benchmark against other institutions with similar demographics in order to enhance the quality of care we provide to our patients and families.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^2\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.\(^3\) The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.


<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>139135109,2, 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY3</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount):</td>
<td>$88,208.50</td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 [P-3]: Test Data System</td>
<td></td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment:</td>
<td>$88,208.50</td>
</tr>
<tr>
<td>Process Milestone 3 [P-4] Conduct PDSA or other QI effort assessing patients receiving full continuum of services across multidisciplines</td>
<td></td>
</tr>
<tr>
<td>Data Source: Advanced Quality Improvement (AQI) projects, Epic, Enterprise Data Warehouse, Rounding and multidisciplinary rounds</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment:</td>
<td>$102,245</td>
</tr>
<tr>
<td>Process Milestone 4 [P-5]:</td>
<td></td>
</tr>
<tr>
<td>Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
</tr>
<tr>
<td>Data Source: Reports and participation in learning collaboratives</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 4 Estimated Incentive Payment:</td>
<td>$102,245</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 [IT-6.1] Improved patient satisfaction:</td>
<td></td>
</tr>
<tr>
<td>Improvement Target: Determine baseline of patient satisfaction measure for new clinic “How well do doctors collaboratively communicate with transition care clinic patients?” Attempt to query no less than 25 percent of new patients;</td>
<td></td>
</tr>
<tr>
<td>Data Source: Press Ganey patient survey, Epic documentation, multidisciplinary round notes</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 4 Estimated Incentive Payment:</td>
<td>$102,245</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment:</td>
<td>$328,136</td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 2 [IT-6.1] Patient Satisfaction Improvement Target: - Maintain or improve score on this patient satisfaction measure for new clinic “How well do doctors communicate with these transition care clinic patients?” Attempt to query no less than 50 percent of new patients;</td>
<td></td>
</tr>
<tr>
<td>Data Source: Press Ganey Patient survey, Epic documentation, multidisciplinary round notes</td>
<td></td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount:</td>
<td>$784,673</td>
</tr>
<tr>
<td>Process Milestone 4 Estimated Incentive Payment:</td>
<td>$102,245</td>
</tr>
<tr>
<td>Outcome Improvement Target 3 Estimated Incentive Payment:</td>
<td>$328,136</td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount:</td>
<td>$784,673</td>
</tr>
<tr>
<td>Outcome Improvement Target 3 Estimated Incentive Payment:</td>
<td>$328,136</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):</td>
<td>$176,417</td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount:</td>
<td>$204,490</td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount:</td>
<td>$328,136</td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount:</td>
<td>$784,673</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects::</td>
<td>139135109.2.1</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TBD in DY3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $1,493,716
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number: 139135109.3.44/Texas Children’s Hospital

Outcome Measure Description:
OD-1 Primary Care and Chronic Disease Management
IT-1.1 Third next available appointment

Process milestone:
   - DY 2 P-1; P-3
   - DY3 P-4; P-5

Outcome Improvement Targets for each year:
   - DY 4 IT 1.1
   - DY 5 IT 1.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor access to care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 2 we will establish a baseline third next available appointment for this population. Because of the continued growth and demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline third next available metric is set in DY2. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is an only a finite amount of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality

---


of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
<table>
<thead>
<tr>
<th>Year</th>
<th>Process Milestone</th>
<th>Data Source</th>
<th>Estimated Incentive Payment</th>
<th>Incentive Payment Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>P-1: Project Planning</td>
<td>EHR/Business Intelligence</td>
<td>$31,599</td>
<td>Third next available appointment</td>
</tr>
<tr>
<td>3</td>
<td>P-4: Conduct PDSA by subspecialty clinic</td>
<td>AQI projects</td>
<td>$36,627</td>
<td>Average number of days to third next available appointment for an office visit for each clinic and/or department. <strong>Sustain availability to 14 days in DY3</strong></td>
</tr>
<tr>
<td>4</td>
<td>P-5: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>Reports and participation in learning collaboratives</td>
<td>$36,627</td>
<td>Third next available appointment</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>Epic Appointment Schedules/Data Warehouse</td>
<td>$117,549</td>
<td><strong>Estimated Incentive Payment</strong>: $281,094</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Outcome Amount:** $63,198

**Year 3 Estimated Outcome Amount:** $73,254

**Year 4 Estimated Outcome Amount:** $117,549

**Year 5 Estimated Outcome Amount:** $281,094

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $535,095
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number: 139135109.3.45/Texas Children’s Hospital

Outcome Measure Description:
OD-1 Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment

Process milestone:
- DY 2 P-1; P-3
- DY 3 P-4; P-5

Outcome Improvement Targets for each year:
- DY 4 IT 1.1
- DY 5 IT 1.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor access to care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 2 we will establish a baseline third next available appointment for this population. Because of the continued growth and demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline third next available metric is set in DY2. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is an only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. 


used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: $22,446.25</td>
<td>Outcome Improvement Target [IT 1.1(1)] Third next available appointment a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. <em>Sustain availability to 14 days in DY3</em> b. Denominator: This measure applies to providers within a reported clinic and/or Department c. Data Source: Epic Appointment Schedules/Data Warehouse Estimated Incentive Payment: $72,037.25</td>
<td>Outcome Improvement Target [IT 1.1(1)] Third next available appointment a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. <em>Sustain availability to 14 days in DY3</em> b. Denominator: This measure applies to providers within a reported clinic and/or Department c. Data Source: Epic Appointment Schedules/Data Warehouse Estimated Incentive Payment: $172,263.00</td>
</tr>
<tr>
<td>Process Milestone 2 [P-3]: Test Data System Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $19,364.75</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $38,729.50</td>
<td>Year 3 Estimated Outcome Amount: $44,892.50</td>
<td>Year 4 Estimated Outcome Amount: $72,037.25</td>
<td>Year 5 Estimated Outcome Amount: $172,263.00</td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong> (add outcome amounts over DYs 2-5): $327,922.25</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan
Region 3

2509
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number: 139135109.3.46/Texas Children’s Hospital

Outcome Measure Description:
OD-1 Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment

Process milestone:
   DY 2 P-1; P-3
   DY3 P-4; P-5

Outcome Improvement Targets for each year:
   DY 4 IT 1.1
   DY 5 IT 1.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor access to care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 2 we will establish a baseline third next available appointment for this population. Because of the continued growth and demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline third next available metric is set in DY2. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is an only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.² The QALY is

used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
### Primary Care and Chronic Disease Management

**Texas Children’s Hospital**

<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $14,802</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process Milestone 2 [P-3]: Test Data System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $14,802</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Improvement Target [IT 1.1(1)] Third next available appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. <strong>Sustain availability to 14 days in DY3</strong></td>
</tr>
<tr>
<td><strong>Denominator:</strong> This measure applies to providers within a reported clinic and/or Department</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Epic Appointment Schedules/Data Warehouse</td>
</tr>
<tr>
<td><strong>Estimated Incentive Payment:</strong> $15,157.25</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $29,604 |

| Year 3 Estimated Outcome Amount: $34,314.50 |

| Year 4 Estimated Outcome Amount: $55,063 |

| Year 5 Estimated Outcome Amount: $131,672.50 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $250,654
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number: 139135109.3.47/Texas Children’s Hospital

Outcome Measure Description:
OD-1 Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment

Process milestone:
  DY 2 P-1; P-3
  DY 3 P-4; P-5

Outcome Improvement Targets for each year:
  DY 4 IT 1.1
  DY 5 IT 1.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor access to care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 2 we will establish a baseline third next available appointment for this population. Because of the continued growth and demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY 4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline third next available metric is set in DY 2. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is an only a finite about of money. The Affordable Care Act focused on the triple aim—improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is

used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
| Related Category 1 or 2 Projects: | 139135109.1.4 |
| Starting Point/Baseline: | 14 days or less |

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]</strong> Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 3 [P-4]</strong> Conduct PDSA by subspecialty clinic</td>
<td><strong>Outcome Improvement Target [IT 1.1(1)]</strong> Third next available appointment</td>
<td><strong>Outcome Improvement Target [IT 1.1(1)]</strong> Third next available appointment</td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td>Data Source: Advanced Quality Improvement (AQI) projects</td>
<td>a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. <strong>Sustain availability to 14 days in DY3</strong></td>
<td>a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. <strong>Sustain availability to 14 days in DY3</strong></td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]</strong>: Test Data System</td>
<td><strong>Process Milestone 4 [P-5]</strong>: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>b. Denominator: This measure applies to providers within a reported clinic and/or Department</td>
<td>b. Denominator: This measure applies to providers within a reported clinic and/or Department</td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td>Data Source: Reports and participation in learning collaboratives</td>
<td>c. Data Source: Epic Appointment Schedules/Data Warehouse</td>
<td>c. Data Source: Epic Appointment Schedules/Data Warehouse</td>
</tr>
</tbody>
</table>

| Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $32,177 | Year 3 Estimated Outcome Amount: $97,674 | Year 4 Estimated Outcome Amount: $59,849.25 | Year 5 Estimated Outcome Amount: $143,117.50 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $272,441.25
**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease Management

**Unique RHP outcome identification number:** 139135109.3.48/Texas Children’s Hospital

**Outcome Measure Description:**
OD-1 Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment

**Process milestone:**
- DY 2 P-1; P-3
- DY3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT 1.1
- DY 5 IT 1.1

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor access to care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 2 we will establish a baseline third next available appointment for this population. Because of the continued growth and demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline third next available metric is set in DY2. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is an only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is


used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
<table>
<thead>
<tr>
<th>Year</th>
<th>Project Milestone</th>
<th>Description</th>
<th>Data Source</th>
<th>Process Milestone Estimated Incentive Payment</th>
<th>Year 2 Estimated Outcome Amount</th>
<th>Year 3 Estimated Outcome Amount</th>
<th>Year 4 Estimated Outcome Amount</th>
<th>Year 5 Estimated Outcome Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Process Milestone 1 [P-1]</td>
<td>Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>EHR/Business Intelligence</td>
<td>$15,881.25</td>
<td>$31,762.50</td>
<td>$36,817</td>
<td>$59,078.25</td>
<td>$141,274.00</td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Process Milestone 3 [P-4]</td>
<td>Conduct PDSA by subspecialty clinic</td>
<td>Advanced Quality Improvement (AQI) projects</td>
<td>$18,408.50</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Process Milestone 4 [P-5]:</td>
<td>Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>Reports and participation in learning collaboratives</td>
<td>$18,408.50</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td>Outcome Improvement Target [IT 1.1(1)]</td>
<td>Third next available appointment</td>
<td>Epic Appointment Schedules/Data Warehouse</td>
<td>$59,078.25</td>
<td>$59,078.25</td>
<td>$59,078.25</td>
<td>$59,078.25</td>
<td>$141,274.00</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $268,931.75
**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease Management

**Unique RHP outcome identification number:** 139135109.3.49/Texas Children’s Hospital

**Outcome Measure Description:**
OD-1 Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment

**Process milestone:**
- DY 2 P-1; P-3
- DY 3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT 1.1
- DY 5 IT 1.1

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor access to care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 2 we will establish a baseline third next available appointment for this population. Because of the continued growth and demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline third next available metric is set in DY2. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is an only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.² The QALY is

---


used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
Related Category 1 or 2 Projects:

Starting Point/Baseline: 14 days or less

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic Data Source: Advanced Quality Improvement (AQI) projects</td>
<td>Outcome Improvement Target [IT 1.1(1)] Third next available appointment a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. Sustain availability to 14 days in DY3 b. Denominator: This measure applies to providers within a reported clinic and/or Department c. Data Source: Epic Appointment Schedules/Data Warehouse Estimated Incentive Payment: $67,264.25</td>
<td>Outcome Improvement Target [IT 1.1(1)] Third next available appointment a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. Sustain availability to 14 days in DY3 b. Denominator: This measure applies to providers within a reported clinic and/or Department c. Data Source: Epic Appointment Schedules/Data Warehouse Estimated Incentive Payment: $160,849</td>
</tr>
<tr>
<td>Process Milestone 2 [P-3]: Test Data System Data Source: Enterprise Data Warehouse reports</td>
<td>Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives</td>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $36,163.50</td>
<td>Year 2 Estimated Outcome Amount: $36,163.50</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $18,081.75</td>
<td>Process Milestone 3 Estimated Incentive Payment: $20,959.25</td>
<td>Year 3 Estimated Outcome Amount: $41,918.50</td>
<td>Year 3 Estimated Outcome Amount: $41,918.50</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $18,081.75</td>
<td>Year 4 Estimated Outcome Amount: $67,264.25</td>
<td>Year 4 Estimated Outcome Amount: $67,264.25</td>
<td>Year 5 Estimated Outcome Amount: $160,849</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $306,195.25</td>
<td>Year 5 Estimated Outcome Amount: $160,849</td>
<td>Year 5 Estimated Outcome Amount: $160,849</td>
<td>Year 5 Estimated Outcome Amount: $160,849</td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number: 139135109.3.50/Texas Children’s Hospital

Outcome Measure Description:
OD-1 Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment

Process milestone:
  DY 2 P-1; P-3
  DY3 P-4; P-5

Outcome Improvement Targets for each year:
  DY 4 IT 1.1
  DY 5 IT 1.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor access to care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 2 we will establish a baseline third next available appointment for this population. Because of the continued growth and demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline third next available metric is set in DY2. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is an only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is


used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
<table>
<thead>
<tr>
<th>139135109.3.50</th>
<th>IT- 1.1</th>
<th>Primary Care and Chronic Disease Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>139135109.1.7</td>
<td>139135109</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>14 days or less</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td>Data Source: Advanced Quality Improvement (AQI) projects</td>
<td>a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. <strong>Sustain availability to 14 days in DY3</strong></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $31,599.50</td>
<td>Process Milestone 3 Estimated Incentive Payment: $36,627.50</td>
<td>b. Denominator: This measure applies to providers within a reported clinic and/or Department</td>
</tr>
<tr>
<td>Process Milestone 2 [P-3]: Test Data System</td>
<td>Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>c. Data Source: Epic Appointment Schedules/Data Warehouse</td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td>Data Source: Reports and participation in learning collaboratives</td>
<td><strong>Estimated Incentive Payment:</strong> $117,549</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $31,599.50</td>
<td>Process Milestone 4 Estimated Incentive Payment: $36,627.50</td>
<td><strong>Estimated Incentive Payment:</strong> $533,595.50</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $63,198.50</td>
<td>Year 3 Estimated Outcome Amount: $73,255</td>
<td>Year 4 Estimated Outcome Amount: $117,549</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $787,598.25
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number: 139135109.3.51/Texas Children’s Hospital

Outcome Measure Description:
OD-1 Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment

Process milestone:
   DY 2 P-1; P-3
   DY3 P-4; P-5

Outcome Improvement Targets for each year:
   DY 4 IT 1.1
   DY 5 IT 1.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor access to care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 2 we will establish a baseline third next available appointment for this population. Because of the continued growth and demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline third next available metric is set in DY2. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is an only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.² The QALY is

used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
### Related Category 1 or 2 Projects:

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1 [P-1] Project Planning** – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- Data Source: EHR/Business Intelligence

**Process Milestone 1 Estimated Incentive Payment (maximum amount):** $31,599.50

**Process Milestone 2 [P-3]: Test Data System**

- Data Source: Enterprise Data Warehouse reports

**Process Milestone 2 Estimated Incentive Payment:** $31,599.50

**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic**

- Data Source: Advanced Quality Improvement (AQI) projects

**Process Milestone 3 Estimated Incentive Payment:** $36,627.50

**Process Milestone 4 [P-5]:**

- Disseminate findings, including lessons learned and best practices, to stakeholders
- Data Source: Reports and participation in learning collaboratives

**Process Milestone 4 Estimated Incentive Payment:** $36,627.50

**Outcome Improvement Target [IT 1.1(1)] Third next available appointment**

- **a.** Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. **Sustain availability to 14 days in DY3**
- **b.** Denominator: This measure applies to providers within a reported clinic and/or Department
- **c.** Data Source: Epic Appointment Schedules/Data Warehouse

**Estimated Incentive Payment:** $117,549

**Year 2 Estimated Outcome Amount:** $63,198.50

**Year 3 Estimated Outcome Amount:** $73,255

**Year 4 Estimated Outcome Amount:** $117,549

**Year 5 Estimated Outcome Amount:** $281,095.50

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $535,098
**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease Management

**Unique RHP outcome identification number:** 139135109.3.52/Texas Children’s Hospital

**Outcome Measure Description:**
OD-1 Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment

**Process milestone:**
- DY 2 P-1; P-3
- DY3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT 1.1
- DY 5 IT 1.1

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor access to care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 2 we will establish a baseline third next available appointment for this population. Because of the continued growth and demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline third next available metric is set in DY2. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is an only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits. Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is


used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>139135109.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>14 days or less</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount):</td>
<td>$13,625.50</td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic</td>
<td></td>
</tr>
<tr>
<td>Data Source: Advanced Quality Improvement (AQI) projects</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment:</td>
<td>$15,793.75</td>
</tr>
<tr>
<td>Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
</tr>
<tr>
<td>Data Source: Reports and participation in learning collaboratives</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 4 Estimated Incentive Payment:</td>
<td>$15,793.75</td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target [IT 1.1(1)] Third next available appointment</td>
<td></td>
</tr>
<tr>
<td>a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. Sustain availability to 14 days in DY3</td>
<td></td>
</tr>
<tr>
<td>b. Denominator: This measure applies to providers within a reported clinic and/or Department</td>
<td></td>
</tr>
<tr>
<td>c. Data Source: Epic Appointment Schedules/Data Warehouse</td>
<td></td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>$50,686.75</td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target [IT 1.1(1)] Third next available appointment</td>
<td></td>
</tr>
<tr>
<td>a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. Sustain availability to 14 days in DY3</td>
<td></td>
</tr>
<tr>
<td>b. Denominator: This measure applies to providers within a reported clinic and/or Department</td>
<td></td>
</tr>
<tr>
<td>c. Data Source: Epic Appointment Schedules/Data Warehouse</td>
<td></td>
</tr>
<tr>
<td>Estimated Incentive Payment:</td>
<td>$121,207</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):</td>
<td>$27,251</td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount:</td>
<td>$31,587.50</td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount:</td>
<td>$50,686.75</td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount:</td>
<td>$121,207</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):</td>
<td>$230,732.25</td>
</tr>
</tbody>
</table>
**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease Management

**Unique RHP outcome identification number:** 139135109.3.53/Texas Children’s Hospital

**Outcome Measure Description:**
OD-1 Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment

**Process milestone:**
- DY 2 P-1; P-3
- DY 3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT 1.1
- DY 5 IT 1.1

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor access to care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 2 we will establish a baseline third next available appointment for this population. Because of the continued growth and demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline third next available metric is set in DY2. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is an only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is

---


used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Primar Care and Chronic Disease Management</th>
<th>139135109.1.12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>14 days or less</td>
<td>139135109</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1] Project Planning</td>
<td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic</td>
<td>Outcome Improvement Target [IT 1.1(1)] Third next available appointment</td>
<td>Outcome Improvement Target [IT 1.1(1)] Third next available appointment</td>
</tr>
</tbody>
</table>
| Data Source: EHR/Business Intelligence | Data Source: Advanced Quality Improvement (AQI) projects | a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. **Sustain availability to 14 days in DY3** | a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department.  
| | Process Milestone 3 Estimated Incentive Payment: $16,343 | **b. Denominator: This measure applies to providers within a reported clinic and/or Department** | **b. Denominator: This measure applies to providers within a reported clinic and/or Department** |
| Process Milestone 1 Estimated Incentive Payment (**maximum amount**): $14,099.25 | Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders | **c. Data Source: Epic Appointment Schedules/Data Warehouse** | **c. Data Source: Epic Appointment Schedules/Data Warehouse** |
| Process Milestone 2 [P-3]: Test Data System | Data Source: Reports and participation in learning collaboratives | Estimated Incentive Payment: $52,449.25 | Estimated Incentive Payment: $125,422 |
| Data Source: Enterprise Data Warehouse reports | Process Milestone 4 Estimated Incentive Payment: $16,343 | | 

<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $28,198.50</th>
<th>Year 3 Estimated Outcome Amount: $32,686</th>
<th>Year 4 Estimated Outcome Amount: $52,449.25</th>
<th>Year 5 Estimated Outcome Amount: $125,422</th>
</tr>
</thead>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $238,755.75
**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease Management

**Unique RHP outcome identification number:** 139135109.3.54/Texas Children’s Hospital

**Outcome Measure Description:**
OD-1 Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment

**Process milestone:**
- DY 2 P-1; P-3
- DY 3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT 1.1
- DY 5 IT 1.1

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor access to care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 2 we will establish a baseline third next available appointment for this population. Because of the continued growth and demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY 4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline third next available metric is set in DY 2. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is an only a finite amount of money. The Affordable Care Act focused on the triple aim—improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is

---


used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
<table>
<thead>
<tr>
<th><strong>IT- 1.1</strong></th>
<th><strong>Primary Care and Chronic Disease Management</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Children’s Hospital</td>
<td>139135109.1.13</td>
</tr>
<tr>
<td>139135109.3.54</td>
<td>139135109</td>
</tr>
<tr>
<td><strong>Related Category 1 or 2 Projects::</strong></td>
<td><strong>139135109.1.13</strong></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>14 days or less</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
</tr>
</tbody>
</table>
| **Process Milestone 1 [P-1] Project Planning** – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans | **Process Milestone 3 [P-3] Conduct PDSA by subspecialty clinic** Data Source: Advanced Quality Improvement (AQI) projects | **Outcome Improvement Target [IT 1.1(1)] Third next available appointment**
   a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. **Sustain availability to 14 days in DY3**
   b. Denominator: This measure applies to providers within a reported clinic and/or Department
   c. Data Source: Epic Appointment Schedules/Data Warehouse **Estimated Incentive Payment:** $75,290.25 | **Outcome Improvement Target [IT 1.1(1)] Third next available appointment**
   a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. **Sustain availability to 14 days in DY3**
   b. Denominator: This measure applies to providers within a reported clinic and/or Department
   c. Data Source: Epic Appointment Schedules/Data Warehouse **Estimated Incentive Payment:** $180,041.50 |
| Data Source: EHR/Business Intelligence | Process Milestone 3 Estimated Incentive Payment: $23,460 | **Year 2 Estimated Outcome Amount:** (add incentive payments amounts from each milestone/outcome improvement target): $40,478.50 | **Year 3 Estimated Outcome Amount:** (add outcome amounts over DYs 2-5): $342,730.25 |
| Process Milestone 1 Estimated Incentive Payment (maximum amount): $20,239.25 | Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives | **Year 3 Estimated Outcome Amount:** $46,920 | **Year 4 Estimated Outcome Amount:** $75,290.25 |
| Process Milestone 2 [P-2] Test Data System Data Source: Enterprise Data Warehouse reports | Process Milestone 4 Estimated Incentive Payment: $23,460 | **Year 4 Estimated Outcome Amount:** $75,290.25 | **Year 5 Estimated Outcome Amount:** $180,041.50 |
| Process Milestone 2 Estimated Incentive Payment: $20,239.25 | **Year 5 Estimated Outcome Amount:** (add outcome amounts over DYs 2-5): $342,730.25 | **TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** |

**Regional Healthcare Partnership Plan**

**Region 3**
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number: 139135109.3.55/Texas Children’s Hospital

Outcome Measure Description:
OD-1 Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment

Process milestone:
  DY 2 P-1; P-3
  DY 3 P-4; P-5

Outcome Improvement Targets for each year:
  DY 4 IT 1.1
  DY 5 IT 1.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor access to care for this population. P-1 and P-3 must be approached in DY 2 and DY 3. In DY 2 we will establish a baseline third next available appointment for this population. Because of the continued growth and demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline third next available metric is set in DY2. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is an only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is


used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Primary Care and Chronic Disease Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>139135109.1.14</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Planning – Engage stakeholders,</td>
<td>subspecialty clinic</td>
</tr>
<tr>
<td>identify current capacity and</td>
<td>Data Source: Advanced Quality</td>
</tr>
<tr>
<td>needed resources, determine</td>
<td>Improvement (AQI) projects</td>
</tr>
<tr>
<td>timelines and document</td>
<td>Process Milestone 3 Estimated</td>
</tr>
<tr>
<td>implementation plans</td>
<td>Incentive Payment: $11,181</td>
</tr>
<tr>
<td></td>
<td><strong>Process Milestone 4 [P-5]:</strong> Disseminate</td>
</tr>
<tr>
<td></td>
<td>findings, including lessons learned and</td>
</tr>
<tr>
<td></td>
<td>best practices, to stakeholders</td>
</tr>
<tr>
<td></td>
<td>Data Source: Reports and participation in</td>
</tr>
<tr>
<td></td>
<td>learning collaboratives</td>
</tr>
<tr>
<td></td>
<td>Process Milestone 4 Estimated</td>
</tr>
<tr>
<td></td>
<td>Incentive Payment: $11,181</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated</td>
<td>Process Milestone 3 Estimated</td>
</tr>
<tr>
<td>Incentive Payment (maximum</td>
<td>Incentive Payment: $11,181</td>
</tr>
<tr>
<td>amount): $9646</td>
<td></td>
</tr>
<tr>
<td>**Process Milestone 2 [P-3]: Test</td>
<td></td>
</tr>
<tr>
<td>Data System**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data Source: Enterprise Data Warehouse</td>
</tr>
<tr>
<td></td>
<td>Reports and participation in learning</td>
</tr>
<tr>
<td></td>
<td>collaborators</td>
</tr>
<tr>
<td></td>
<td>Process Milestone 2 Estimated</td>
</tr>
<tr>
<td></td>
<td>Incentive Payment: $9646</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td>Year 3 Estimated Outcome Amount: $22,362</td>
</tr>
<tr>
<td>(add incentive payments amounts</td>
<td>Year 4 Estimated Outcome Amount: $35883</td>
</tr>
<tr>
<td>from each milestone/outcome</td>
<td>Year 5 Estimated Outcome Amount: $85807</td>
</tr>
<tr>
<td>improvement target): $19292</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $163,344
**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease Management

**Unique RHP outcome identification number:** 139135109.3.56/Texas Children’s Hospital

**Outcome Measure Description:**
OD-1 Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment

**Process milestone:**
- DY 2 P-1; P-3
- DY3 P-4; P-5

**Outcome Improvement Targets for each year:**
- DY 4 IT 1.1
- DY 5 IT 1.1

**Rationale:** Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor access to care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 2 we will establish a baseline third next available appointment for this population. Because of the continued growth and demand for patient care services, the outcome measure of third next available appointment must be coupled and considered with the metric of patient visit volume growth compared to baseline to truly measure patient access. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline third next available metric is set in DY2. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is an only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

**Outcome Measure Valuation:** All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is

---


used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>139135109.1.15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>14 days or less</td>
</tr>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment (maximum amount): $26,157</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 [P-3]: Test Data System Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $26,157</td>
<td></td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: $30,319.25</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment: $30,319.25</td>
<td></td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Outcome Improvement Target [IT 1.1(1)] Third next available appointment a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. Sustain availability to 14 days in DY3 b. Denominator: This measure applies to providers within a reported clinic and/or Department c. Data Source: Epic Appointment Schedules/Data Warehouse Estimated Incentive Payment: $97,303.75</td>
<td></td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Outcome Improvement Target [IT 1.1(1)] Third next available appointment a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department. Sustain availability to 14 days in DY3 b. Denominator: This measure applies to providers within a reported clinic and/or Department c. Data Source: Epic Appointment Schedules/Data Warehouse Estimated Incentive Payment: $57,683</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $52,314</td>
<td></td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount: $60,638.50</td>
<td></td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount: $97,303.75</td>
<td></td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount: $57,683</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $267,939
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number: 139135109.3.57

Outcome Measure Description:
OD-1 Primary Care and Chronic Disease Management

IT-1.1 Third next available appointment

Process milestone:
   DY 2 P-1; P-3
   DY3 P-4; P-5

Outcome Improvement Targets for each year:
   DY 4 IT 1.1
   DY 5 IT 1.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of access to care and quality of life for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline third next available appointment and baseline initial score on the Edinburgh Postnatal Depression Scale for quality of life for this population. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline third next available metric is set in DY3. We will aim for a post-treatment score of 13 on the Edinburgh Postnatal Depression Scale as the improvement target for quality of life. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is an only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.¹ Our valuation includes an increase in the patient’s quality of life. We used a conservative Quality Adjusted Life Year

(“QALY”) per year and a percentage of that QALY for the pediatric population. The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

---

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Data Source: Advanced Quality Improvement (AQI) projects</td>
<td>a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department.</td>
</tr>
<tr>
<td>Data Source: EHR/Business Intelligence</td>
<td>Process Milestone 3 Estimated Incentive Payment: $18,313.75</td>
<td>b. Denominator: This measure applies to providers within a reported clinic and/or Department</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $15,797.25</td>
<td>Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>c. Data Source: Epic Appointment Schedules/Data Warehouse</td>
</tr>
<tr>
<td>Process Milestone 2 [P-3]: Test Data System</td>
<td>Data Source: Reports and participation in learning collaboratives</td>
<td>Estimated Incentive Payment: $58,774.50</td>
</tr>
<tr>
<td>Data Source: Enterprise Data Warehouse reports</td>
<td>Process Milestone 4 Estimated Incentive Payment: $18,313.75</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $15,797.25</td>
<td>Ownership Improvement Target [IT 1.1] Third next available appointment</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $31,594.50</td>
<td>a. Numerator: Continuous variable statement: Average number of days to third next available appointment for an office visit for each clinic and/or department.</td>
<td></td>
</tr>
<tr>
<td>Year 3 Estimated Outcome Amount: $36,627.50</td>
<td>b. Denominator: This measure applies to providers within a reported clinic and/or Department</td>
<td></td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount: $58,774.50</td>
<td>c. Data Source: Epic Appointment Schedules/Data Warehouse</td>
<td></td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount: $140,547.50</td>
<td>Estimated Incentive Payment: $140,547.50</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $267,548.50

Year 2 (10/1/2012 – 9/30/2013)

Year 3 (10/1/2013 – 9/30/2014)

Year 4 (10/1/2014 – 9/30/2015)

Year 5 (10/1/2015 – 9/30/2016)
The Methodist Hospital
Pass 1
Title of Outcome Measure (Improvement Target): IT 1.18 - Follow up after Hospitalization for Mental Illness

Performing Provider Name / TPI: The Methodist Hospital / 137949705

Unique RHP outcome identification number(s): 137949705.3.1

Outcome Measure Description:
IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)
Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Our goal is that by year four we will have 60% with follow up within 30 days, and by year 5 we will have 80%.
Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. As it is difficult to arrange appointments so close to discharge because of patient and physician factors, our goal is that by the fourth year we will have 40% follow up within seven days and by the fifth year, 50%.

Process Milestones:
- DY2:  
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:  
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year:
- DY4: IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)  
  - Improvement Target: 60% above baseline
- DY5: IT 1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)  
  - Improvement Target: 80% above baseline

Rationale:
Process milestones in DY 2 are focused on training, education and partnership development. These efforts are largely external efforts focused on our medical staff, collaborating healthcare providers and community partners. Process milestones in DY 3 are focused on establishing our baseline, factors that are driving utilization and establishing a process to follow up with patients post-discharge. These are largely internal efforts with our hospital based work teams.

Outcome Measure Valuation:
We have selected IT 1.18 as our quality outcome metric as we feel this is most important quality outcome to determine the success or impact of our project. Through a focused effort to follow up and coordinate the post discharge care needs of our targeted population we will demonstrate true
value to the community. Meaning, our targeted population will receive higher quality care in the correct care setting, all at a lower cost.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Process Milestone 2 [P-2]: Establish baseline</th>
<th>Outcome Improvement Target 1 [IT-1.18]: Follow-Up After Hospitalization for Mental Illness - NQF 0576236</th>
<th>Outcome Improvement Target 2 [IT-1.18]: Follow-Up After Hospitalization for Mental Illness - NQF 0576236</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: EHR; Business Intelligence</td>
<td>Data Source: EMR</td>
<td>Improvement Target: 60% above baseline</td>
<td>Improvement Target: 80% above baseline</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment (maximum amount): $452,644</td>
<td>Process Milestone 2 Estimated Incentive Payment: $452,644</td>
<td>Data Source: EHR, Claims</td>
<td>Data Source: EHR, Claims</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $452,644</td>
<td>Year 3 Estimated Outcome Amount: $452,644</td>
<td>Year 4 Estimated Outcome Amount: $678,966</td>
<td>Year 5 Estimated Outcome Amount: $1,493,725</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYS 2-5)*: $3,077,979
The University of Texas Health Science Center - Houston

Pass 1
**Title of Outcome Measure (Improvement Target):** OD-12 Primary Care and Primary Prevention

**Unique RHP outcome identification number(s):** 111810101.3.1

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**
IT-12.2 Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)
   Numerator: Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. Denominator: Women aged 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix are excluded.

**Process Milestones:**
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
DY4:
IT-12.2 Increase by 3% the percentage of women patients of UT Physicians aged 21 to 64 that have received a PAP in the measurement year or two prior years. Women who have had a complete hysterectomy with no residual cervix are excluded.
DY5:
IT-12.2 Increase by 5% the percentage of women patients of UT Physicians aged 21 to 64 that have received a PAP in the measurement year or two prior years. Women who have had a complete hysterectomy with no residual cervix are excluded.

**Rationale:**
By increasing primary care capacity, preventative care and recommended screenings to detect cancer early would be available to more people in the community. By screening for early stages of disease before symptoms occur, patients testing positive can receive appropriate follow-up diagnostic tests, treatment, and follow-up. Early detection may reduce the impact of cancer when treatment may be easier and more effective than for an advanced cancer diagnosis in terms of the disease burden, harm and cost. Along with additional physicians to see patients for primary care, the extended hours would make it more convenient for patients to get these early screening tests.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
### Related Category 1 or 2 Projects:

**Starting Point/Baseline:**
To be determined during DY3.

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
| Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
   Data Source: Project reports and documents  
   Process Milestone 1 Estimated Incentive Payment: $ 78,980 | Process Milestone 2 [P-2]: Establish baseline rates  
   Data Source: Provider reports  
   Process Milestone 2 Estimated Incentive Payment: $ 94,024 | Outcome Improvement Target 1 [IT-12.2]: Increase by 3% the percentage of women patients of UT Physicians aged 21 to 64 that have received a PAP in the measurement year or two prior years. Women who have had a complete hysterectomy with no residual cervix are excluded.  
   Data Source: EHR, Claims  
   Process Milestone 3 Estimated Incentive Payment: $ 94,024 | Outcome Improvement Target 2 [IT-12.2]: Increase by 5% the percentage of women patients of UT Physicians aged 21 to 64 that have received a PAP in the measurement year or two prior years. Women who have had a complete hysterectomy with no residual cervix are excluded.  
   Data Source: EHR, Claims  
   Outcome Improvement Target 1 Estimated Incentive Payment: $ 195,570 |
| Year 2 Estimated Outcome Amount: $ 78,980 | Year 3 Estimated Outcome Amount: $ 188,048 | Year 4 Estimated Outcome Amount: $ 195,570 | Year 5 Estimated Outcome Amount: $ 442,945 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 905,543
**Title of Outcome Measure (Improvement Target):** OD-12 Primary Care and Primary Prevention

**Unique RHP outcome identification number(s):** 111810101.3.2

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**
IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)
   Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period. Denominator: Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded.

**Process Milestones:**

DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**

DY4:
IT-12.1 Increase by 3% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded.

DY5:
IT-12.1 Increase by 5% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded.

**Rationale:**
By increasing primary care capacity, preventative care and recommended screenings to detect cancer early would be available to more people in the community. By screening for early stages of disease before symptoms occur, patients testing positive can receive appropriate follow-up diagnostic tests, treatment, and follow-up. Early detection may reduce the impact of cancer when treatment may be easier and more effective than for an advanced cancer diagnosis in terms of the disease burden, harm and cost. Along with additional physicians to see patients for primary care, the extended hours would make it more convenient for patients to get these early screening tests.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
| Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
Data Source: Project reports and documents | Year 2 (10/1/2012 – 9/30/2013)  
Process Milestone 2 [P-2]: Establish baseline rates  
Data Source: Provider reports  
Process Milestone 2 Estimated Incentive Payment: $ 94,024 | Year 3 (10/1/2013 – 9/30/2014)  
Process Milestone 2 Estimated Incentive Payment: $ 94,024 | Year 4 (10/1/2014 – 9/30/2015)  
Outcome Improvement Target 1 [IT-12.1]: Increase by 3% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded.  
Data Source: EHR, Claims  
Outcome Improvement Target 1 Estimated Incentive Payment: $ 195,570 | Year 5 (10/1/2015 – 9/30/2016)  
Outcome Improvement Target 2 [IT-12.1]: Increase by 5% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded.  
Data Source: EHR, Claims  
Outcome Improvement Target 2 Estimated Incentive Payment: $ 442,945 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 78,980</td>
<td>Year 3 Estimated Outcome Amount: $ 188,048</td>
<td>Year 4 Estimated Outcome Amount: $ 195,570</td>
<td>Year 5 Estimated Outcome Amount: $ 442,945</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 905,543
Title of Outcome Measure (Improvement Target): OD-12 Primary Care and Primary Prevention

Unique RHP outcome identification number(s): 111810101.3.3
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)
   Numerator: Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years
   Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-12.3 Increase by 3% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded.
DY5:
IT-12.3 Increase by 5% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded.

Rationale:
By increasing primary care capacity, preventative care and recommended screenings to detect cancer early would be available to more people in the community. By screening for early stages of disease before symptoms occur, patients testing positive can receive appropriate follow-up diagnostic tests, treatment, and follow-up. Early detection may reduce the impact of cancer when treatment may be easier and more effective than for an advanced cancer diagnosis in terms of the disease burden, harm and cost. Along with additional physicians to see patients for primary care, the extended hours would make it more convenient for patients to get these early screening tests.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
**Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)**

*UTHealth, UTPhysicians*

### Related Category 1 or 2 Projects:

111810101.1

### Starting Point/Baseline:

To be determined during DY3.

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports</td>
<td>Outcome Improvement Target 1 [IT-12.3]: Increase by 3% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded. Data Source: EHR, Claims</td>
<td>Outcome Improvement Target 2 [IT-12.3]: Increase by 5% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded. Data Source: EHR, Claims</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 78,980</td>
<td>Year 3 Estimated Outcome Amount: $ 188,048</td>
<td>Year 4 Estimated Outcome Amount: $ 195,570</td>
<td>Year 5 Estimated Outcome Amount: $ 442,945</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 905,543
**Title of Outcome Measure (Improvement Target):** OD-14 Workforce Development

**Unique RHP outcome identification number(s):** 111810101.3.4

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**
IT – 14.6 Percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA)

**Process Milestones:**

**DY2:**
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

**DY3:**
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
DY4: Increase by 3% over baseline the percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA)
DY5: Increase by 5% over baseline the percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA)

**Rationale:**
In order to move closer to a well-functioning health care delivery system, providers must have training that prepares them for the coordinated, outcomes- and evidence-based health care systems they will be entering. A recent nation-wide study conducted with medical students found that students felt their training was appropriate in terms of clinical decision making and clinical care, but felt that their training had not prepared them appropriately for practicing medicine (Patel MS, Davis MM, Lypson ML. Medical Student Perceptions of Education in Health Care Systems. September, 2009. Academic Medicine, 84(9):1301-6).

By training residents in the new primary care in continuity care clinics located in HPSAs or MUAs, it is expected that more of them will continue to practice in these areas. Furthermore, residents that have lived in HPSAs or MUAs may be more likely to return to these areas to practice medicine. Since there will not be time during the life of this project to determine the influence of the training on choices of practice area, this will be used as one of three indicators of likelihood to practice in an area of need.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>111810101.3.4</td>
<td>3.IT-14.6</td>
</tr>
<tr>
<td>UTHealth, UTPhysicians</td>
<td></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>To be determined during DY3.</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
</tr>
<tr>
<td>(10/1/2012 – 9/30/2013)</td>
<td>(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
</tr>
<tr>
<td></td>
<td>Data Source: Project reports and documents</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 29,408</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 35,009</td>
</tr>
<tr>
<td></td>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
</tr>
<tr>
<td></td>
<td>Data Source: Project reports, EMR, claims</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 29,408</td>
<td>Process Milestone 3 Estimated Incentive Payment: $ 35,009</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong></td>
<td><strong>Year 3 Estimated Outcome Amount:</strong></td>
</tr>
<tr>
<td>$ 29,408</td>
<td>$ 70,018</td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1 [IT-14.6]: Increase by 3% over baseline the percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA) Data Source: Survey</strong></td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong> $ 72,819</td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 2 [IT-14.6]: Increase by 5% over baseline the percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA) Data Source: Survey</strong></td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong> $ 164,079</td>
</tr>
<tr>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
</tr>
<tr>
<td>(10/1/2014 – 9/30/2015)</td>
<td>(10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td><strong>Process Milestone 1 Estimated Incentive Payment: $ 29,408</strong></td>
<td><strong>Process Milestone 2 Estimated Incentive Payment: $ 35,009</strong></td>
</tr>
<tr>
<td><strong>Process Milestone 3 Estimated Incentive Payment: $ 35,009</strong></td>
<td><strong>Outcome Improvement Target 1 Estimated Incentive Payment:</strong> $ 72,819</td>
</tr>
<tr>
<td><strong>Process Milestone 4 Estimated Incentive Payment: $ 72,819</strong></td>
<td><strong>Outcome Improvement Target 2 Estimated Incentive Payment:</strong> $ 164,079</td>
</tr>
<tr>
<td><strong>Year 4 Estimated Outcome Amount:</strong></td>
<td><strong>Year 5 Estimated Outcome Amount:</strong></td>
</tr>
<tr>
<td>$ 72,819</td>
<td>$ 164,079</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 336,323
Title of Outcome Measure (Improvement Target): OD-14 Workforce Development

Unique RHP outcome identification number(s): 111810101.3.5
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT – 14. 7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4: Increase by 3% over baseline the percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey
DY5: Increase by 5% over baseline the percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

Rationale:
In order to move closer to a well-functioning health care delivery system, providers must have training that prepares them for the coordinated, outcomes- and evidence-based health care systems they will be entering. A recent nation-wide study conducted with medical students found that students felt their training was appropriate in terms of clinical decision making and clinical care, but felt that their training had not prepared them appropriately for practicing medicine (Patel MS, Davis MM, Lypson ML. Medical Student Perceptions of Education in Health Care Systems. September, 2009. Academic Medicine, 84(9):1301-6).

By training residents in the new primary care in continuity care clinics located in HPSAs or MUAs, it is expected that more of them will continue to practice in these areas. Since there will not be time during the life of this project to determine the influence of the training on choices of practice area, this measure will be used as one of three indicators of likelihood to practice in an area of need.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
<td>Outcome Improvement Target 1 [IT– 14. 7]: Increase by 3% over baseline the percent of trainees who report that they plan to practice in HPSAs or MUAs</td>
<td>Outcome Improvement Target 2 [IT– 14. 7]: Increase by 5% over baseline the percent of trainees who report that they plan to practice in HPSAs or MUAs</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: Survey</td>
<td>Data Source: Survey</td>
</tr>
<tr>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 35,009</td>
<td>Process Milestone 3 Estimated Incentive Payment: $ 35,009</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 72,819</td>
</tr>
<tr>
<td>Data Source: Project reports, EMR, claims</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 72,819</td>
<td>Process Milestone 3 Estimated Incentive Payment: $ 35,009</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 164,079</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 29,408</td>
<td>Year 2 Estimated Outcome Amount: $ 29,408</td>
<td>Year 3 Estimated Outcome Amount: $ 70,018</td>
<td>Year 4 Estimated Outcome Amount: $ 72,819</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 29,408</td>
<td>Year 3 Estimated Outcome Amount: $ 70,018</td>
<td>Year 4 Estimated Outcome Amount: $ 72,819</td>
<td>Year 5 Estimated Outcome Amount: $ 164,079</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 336,323
Title of Outcome Measure (Improvement Target): OD-14 Workforce Development

Unique RHP outcome identification number(s): 111810101.3
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4: Increase by 3% over baseline the percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey
DY5: Increase by 5% over baseline the percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Rationale:
In order to move closer to a well-functioning health care delivery system, providers must have training that prepares them for the coordinated, outcomes- and evidence-based health care systems they will be entering. A recent nation-wide study conducted with medical students found that students felt their training was appropriate in terms of clinical decision making and clinical care, but felt that their training had not prepared them appropriately for practicing medicine (Patel MS, Davis MM, Lypson ML. Medical Student Perceptions of Education in Health Care Systems. September, 2009. Academic Medicine, 84(9):1301-6).

By training residents in the new primary care in continuity care clinics located in HPSAs or MUAs, it is expected that more of them will continue to practice in these areas. Since there will not be time during the life of this project to determine the influence of the training on choices of practice area, this will be used as one of three indicators of likelihood to practice in an area of need.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
### Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

**UTHealth, UT Physicians**

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>111810101.1.2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>To be determined during DY3.</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Process Milestone 2 Estimated Incentive Payment: $35,009</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $29,407</td>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
</tr>
<tr>
<td>Data Source: Project reports, EMR, claims</td>
<td>Process Milestone 3 Estimated Incentive Payment: $35,009</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $29,407</td>
<td>Year 3 Estimated Outcome Amount: $70,018</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $336,321
**Title of Outcome Measure (Improvement Target):** OD-11 Addressing Health Disparities in Minority Populations

**Unique RHP outcome identification number(s):** 111810101.3.7

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**
IT-11.5 (IT-2.10) Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure (Standalone measure) (IT-2.10 Flu and pneumonia Admission Rate)

For the Hispanic population:
Numerator: All discharges of age 18 years and older with a principal diagnosis code of flu or pneumonia.
Denominator: Population in Metro Area or county, age 18 years and older.

**Process Milestones:**
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
DY4:
IT-11.5 (IT-2.10) Reduce by 3% the percentage of all discharges of Hispanics age 18 years and older with a principal diagnosis code of flu or pneumonia, who are patients of UT Physicians.
DY5:
IT-11.5 (IT-2.10) Reduce by 5% the percentage of all discharges of Hispanics age 18 years and older with a principal diagnosis code of flu or pneumonia, who are patients of UT Physicians.

**Rationale:**
Hispanics have a high rate of death from influenza and pneumonia (2009 CDC, Minority Health. http://www.cdc.gov/minorityhealth/populations/REMP/hispanic.html#10). Harris County and the UT Physician service areas have considerably more Hispanics (Harris County-40.8%; Bayshore-49.2%; Bellair-46%; Cinco Ranch-26.2%; Sienna Village-23.5%) than the national average (16.3%). (Population race/ethnicity statistics are from the U.S. Census Bureau, 2010 Census Summary File 1, Tables P8, PCT4, PCT5, and PCT8. Note: Derived from 2010 Census Summary File 1 data by the Texas State Data Center.) The delivery of culturally sensitive care is more likely to increase the adoption of preventive services such as influenza vaccinations among Hispanics. CHWs have been proven to be effective in serving as linkages between patients and the health system, helping patients to navigate the daunting challenges posed by the fragmented nature of health care delivery on the US. Most CHWs come from the local population, are in touch with the community, hence they are able to aid the health system to deliver culturally sensitive care, and by so doing will help address health disparities in minority populations.
Therefore, a reduction in admissions for flu and pneumonia for the Hispanic population served UT Physicians would be an appropriate measure for the success of this program.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>111810101.3.7</th>
<th>3.IT-11.5 (IT-2.10)</th>
<th>Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure (Standalone measure) (IT-2.10 Flu and pneumonia Admission Rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>UTHealth, UTPhysicians</td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:**

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
</tr>
</thead>
<tbody>
<tr>
<td>To be determined during DY3.</td>
</tr>
</tbody>
</table>

**Year 2 (10/1/2012 – 9/30/2013)**

<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Process Milestone 2 [P-2]: Establish baseline rates</th>
<th>Process Milestone 3 [P-3]: Develop and test data systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: Project reports, EMR, claims</td>
</tr>
</tbody>
</table>

**Year 3 (10/1/2013 – 9/30/2014)**

<table>
<thead>
<tr>
<th>Outcome Improvement Target 1 [IT-11.5 (IT-2.10)]: Reduce by 3% the percentage of all discharges of Hispanics age 18 years and older with a principal diagnosis code of flu or pneumonia, who are patients of UT Physicians.</th>
<th>Data Source: EMR, Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 337,046</td>
</tr>
</tbody>
</table>

**Year 4 (10/1/2014 – 9/30/2015)**

<table>
<thead>
<tr>
<th>Outcome Improvement Target 2 [IT-11.5 (IT-2.10)]: Reduce by 5% the percentage of all discharges of Hispanics age 18 years and older with a principal diagnosis code of flu or pneumonia, who are patients of UT Physicians.</th>
<th>Data Source: EMR, Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 747,663</td>
</tr>
</tbody>
</table>

**Year 5 (10/1/2015 – 9/30/2016)**

| Year 2 Estimated Outcome Amount: $ 136,115 | Year 3 Estimated Outcome Amount: $ 324,083 | Year 4 Estimated Outcome Amount: $ 337,046 | Year 5 Estimated Outcome Amount: $ 747,663 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 1,544,907
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 111810101.3.8
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)12 (Stand-alone measure)
   Improve the number of patients 18 to 85 years of age with a diagnosis of hypertension, whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-1.7 Improve by 3% the percentage of UT Physician’s patients (ages 18 to 85 years) with a diagnosis of hypertension, whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year.
DY5:
IT-1.7 Improve by 5% the percentage of UT Physician’s patients (ages 18 to 85 years) with a diagnosis of hypertension, whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year.

Rationale:
Effective control of blood pressure significantly decreases the risk of coronary artery disease, congestive heart failure, and stroke in hypertensive patients. For instance a 12-point to 13-point reduction in blood pressure can lower the risk of heart attack by 21%, stroke by 37%, and total cardiovascular deaths by 25% (Rein DB, Constantine RT, Orenstein D, Chen H, Jones P, Brownstein JN, et al. A cost evaluation of the Georgia Stroke and Heart Attack Prevention Program. Prev Chronic Dis [serial online] 2006). Use of the chronic disease registry will enable care teams to more closely monitor patients with hypertension and enable them to provide better care, which is expected to leading to better blood pressure control among our hypertensive patients.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration
year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Process Milestone 2 [P-2]: Establish baseline rates</th>
<th>Outcome Improvement Target 1 [IT-1.7]: Improve by 3% the percentage of UT Physician’s patients (ages 18 to 85 years) with a diagnosis of hypertension, whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year.</th>
<th>Outcome Improvement Target 2 [IT-1.7]: Improve by 5% the percentage of UT Physician’s patients (ages 18 to 85 years) with a diagnosis of hypertension, whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: EMR, Registry</td>
<td>Data Source: EMR, Registry</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 95,785</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 114,029</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 237,180</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 532,568</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 95,785</td>
<td>Year 3 Estimated Outcome Amount: $ 228,058</td>
<td>Year 4 Estimated Outcome Amount: $ 237,180</td>
<td>Year 5 Estimated Outcome Amount: $ 532,568</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 1,093,591
**Title of Outcome Measure (Improvement Target):** OD-9 Right Care, Right Setting

**Unique RHP outcome identification number(s):** 111810101.3.9  
**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**  
IT-9.2 ED appropriate utilization (Stand-alone measure)  
Reduce Emergency Department visits for  
- Asthma  
- COPD  
- CHF  
- Diabetes  
- Hypertension

**Process Milestones:**  
DY2:  
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
DY3:  
P-3 Develop and test data systems  
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**  
DY4:  
IT-9.2 Reduce by 3% the percentage of Emergency Department visits for asthma, COPD, CHF, Diabetes, and Hypertension.  
DY5:  
IT-9.2 Reduce by 5% the percentage of Emergency Department visits for asthma, COPD, CHF, Diabetes, and Hypertension.

**Rationale:**  
We expect the use of the Nurse-line medical triage call center to reduce ED visits, which is an indicator of access to appropriate primary health care. The Nurse-line will provide urgent medical advice and facilitate access to the appropriate level and site of care when needed, thereby improving patient clinical indicators, health outcomes, and reduce unnecessary acute and emergency care utilization. Thus measuring ED visits for the targeted chronic diseases will be a good way of assessing the project’s impact.

**Outcome Measure Valuation:**  
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>111810101.3.9</th>
<th>3.IT-9.2</th>
<th>ED appropriate utilization (Stand-alone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTHealth, UTPhysicians</td>
<td>111810101.5</td>
<td></td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:**

**Starting Point/Baseline:**

To be determined during DY3.

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
<td>Outcome Improvement Target 1 [IT-9.2]: Reduce by 3% the percentage of Emergency Department visits for asthma, COPD, CHF, Diabetes, and Hypertension.</td>
<td>Outcome Improvement Target 2 [IT-9.2]: Reduce by 5% the percentage of Emergency Department visits for asthma, COPD, CHF, Diabetes, and Hypertension.</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: EMR, Claims</td>
<td>Data Source: EMR, Claims</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $214,255</td>
<td>Process Milestone 2 Estimated Incentive Payment: $255,065</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $530,536</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $1,164,410</td>
</tr>
<tr>
<td></td>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data Source: Project reports, EMR, claims</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Process Milestone 3 Estimated Incentive Payment: $255,066</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Year 2 Estimated Outcome Amount: $214,255</td>
<td>Year 3 Estimated Outcome Amount: $510,131</td>
<td>Year 4 Estimated Outcome Amount: $530,536</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $2,419,332
**Title of Outcome Measure (Improvement Target):** OD-12 Primary Care and Primary Prevention

**Unique RHP outcome identification number(s):** 111810101.3.10

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**
IT-12.2 Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)

- **Numerator:** Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years.
- **Denominator:** Women aged 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix are excluded.

**Process Milestones:**
- **DY2:**
  - P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- **DY3:**
  - P-3 Develop and test data systems
  - P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
- **DY4:**
  - IT-12.2 Increase by 3% the percentage of women patients of UT Physicians aged 21 to 64 that have received a PAP in the measurement year or two prior years. Women who have had a complete hysterectomy with no residual cervix are excluded.
- **DY5:**
  - IT-12.2 Increase by 5% the percentage of women patients of UT Physicians aged 21 to 64 that have received a PAP in the measurement year or two prior years. Women who have had a complete hysterectomy with no residual cervix are excluded.

**Rationale:**
By increasing primary care capacity, preventative care and recommended screenings to detect cancer early would be available to more people in the community. By screening for early stages of disease before symptoms occur, patients testing positive can receive appropriate follow-up diagnostic tests, treatment, and follow-up. Early detection may reduce the impact of cancer when treatment may be easier and more effective than for an advanced cancer diagnosis in terms of the disease burden, harm and cost. Along with additional physicians to see patients for primary care, the extended hours would make it more convenient for patients to get these early screening tests.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
### Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)

**UTHealth, UTPhysicians**

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong></td>
<td>Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process baseline rates</td>
<td>Outcome Improvement Target 1 [IT-12.2]: Increase by 3% the percentage of women patients of UT Physicians aged 21 to 64 that have received a PAP in the measurement year or two prior years. Women who have had a complete hysterectomy with no residual cervix are excluded.</td>
<td>Outcome Improvement Target 2 [IT-12.2]: Increase by 5% the percentage of women patients of UT Physicians aged 21 to 64 that have received a PAP in the measurement year or two prior years. Women who have had a complete hysterectomy with no residual cervix are excluded.</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: EHR, Claims</td>
<td>Data Source: EHR, Claims</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 72,259</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 86,022</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 178,926</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 392,618</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 72,259</td>
<td>Year 3 Estimated Outcome Amount: $ 172,044</td>
<td>Year 4 Estimated Outcome Amount: $ 178,926</td>
<td>Year 5 Estimated Outcome Amount: $ 392,618</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 815,847
Title of Outcome Measure (Improvement Target): OD-12 Primary Care and Primary Prevention

Unique RHP outcome identification number(s): 111810101.3.11
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)
Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period. Denominator: Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded.

Process Milestones:
DY2: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3: P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-12.1 Increase by 3% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded.
DY5:
IT-12.1 Increase by 5% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded.

Rationale:
By increasing primary care capacity, preventative care and recommended screenings to detect cancer early would be available to more people in the community. By screening for early stages of disease before symptoms occur, patients testing positive can receive appropriate follow-up diagnostic tests, treatment, and follow-up. Early detection may reduce the impact of cancer when treatment may be easier and more effective than for an advanced cancer diagnosis in terms of the disease burden, harm and cost. Along with additional physicians to see patients for primary care, the extended hours would make it more convenient for patients to get these early screening tests.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>111810101.3.11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be determined during DY3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
<td>Outcome Improvement Target 1 [IT-12.1]: Increase by 3% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded.</td>
<td>Outcome Improvement Target 2 [IT-12.1]: Increase by 5% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded.</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: EHR, Claims</td>
<td>Data Source: EHR, Claims</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $72,259</td>
<td>Process Milestone 2 Estimated Incentive Payment: $86,022</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $178,926</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $392,617</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $72,259</td>
<td>Year 3 Estimated Outcome Amount: $172,044</td>
<td>Year 4 Estimated Outcome Amount: $178,926</td>
<td>Year 5 Estimated Outcome Amount: $392,617</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $815,846
**Title of Outcome Measure (Improvement Target):** OD-12 Primary Care and Primary Prevention

**Unique RHP outcome identification number(s):** 111810101.3.12  
**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**  
IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)  
   Numerator: Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years  
   Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.

**Process Milestones:**  
DY2:  
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
DY3:  
P-3 Develop and test data systems  
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**  
DY4:  
IT-12.3 Increase by 3% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded.  
DY5:  
IT-12.3 Increase by 5% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded.

**Rationale:**  
By increasing primary care capacity, preventative care and recommended screenings to detect cancer early would be available to more people in the community. By screening for early stages of disease before symptoms occur, patients testing positive can receive appropriate follow-up diagnostic tests, treatment, and follow-up. Early detection may reduce the impact of cancer when treatment may be easier and more effective than for an advanced cancer diagnosis in terms of the disease burden, harm and cost. Along with additional physicians to see patients for primary care, the extended hours would make it more convenient for patients to get these early screening tests.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Starting Point/Baseline:</th>
</tr>
</thead>
<tbody>
<tr>
<td>111810101.1.6</td>
<td>To be determined during DY3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2  (10/1/2012 – 9/30/2013)</th>
<th>Year 3  (10/1/2013 – 9/30/2014)</th>
<th>Year 4  (10/1/2014 – 9/30/2015)</th>
<th>Year 5  (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
<td>Outcome Improvement Target 1 [IT-12.3]: Increase by 3% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded.</td>
<td>Outcome Improvement Target 2 [IT-12.3]: Increase by 5% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded.</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: EHR, Claims</td>
<td>Data Source: EHR, Claims</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 72,259</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 86,022</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 178,926</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 392,617</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 72,259</td>
<td>Year 3 Estimated Outcome Amount: $ 172,044</td>
<td>Year 4 Estimated Outcome Amount: $ 178,926</td>
<td>Year 5 Estimated Outcome Amount: $ 392,617</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 815,846
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 111810101.3.13
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-1.1 Third next available appointment (Non-standalone measure)
Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient, or return visit/exam. The goals will be to decrease number of days to third next available appointment to two days for Specialty Care.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-1.1 Reduce by 1 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care.
DY5:
IT-1.1 Reduce by 2 days over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to one day for Specialty Care.

Rationale:
Access to care services can have an impact on healthcare outcomes, by providing early screening and treatment and patients are more likely to get these services when they are able to get appointments when first needed that accommodate their schedule. Since the goal of the project is to increase access to care and the third next available appointment is the healthcare industry's standard measure of access to care, we have chosen this outcome measure.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
### Related Category 1 or 2 Projects:

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

#### Year 2
(10/1/2012 - 9/30/2013)

- **Process Milestone 1 [P-1]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - Data Source: Project reports and documents

- **Process Milestone 2 [P-2]:** Establish baseline rates
  - Data Source: Provider reports

- **Process Milestone 3 [P-3]:** Develop and test data systems
  - Data Source: Project reports, EMR, claims

- **Process Milestone 1 Estimated Incentive Payment:** $114,689

#### Year 3
(10/1/2013 - 9/30/2014)

- **Process Milestone 2 Estimated Incentive Payment:** $136,535

- **Process Milestone 3 Estimated Incentive Payment:** $136,535

#### Year 4
(10/1/2014 - 9/30/2015)

- **Outcome Improvement Target 1 [IT-1.1]:** Reduce by 1 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care.
  - Data Source: Appointment management system

- **Outcome Improvement Target 1 Estimated Incentive Payment:** $283,993

#### Year 5
(10/1/2015 - 9/30/2016)

- **Outcome Improvement Target 2 [IT-1.1]:** Reduce by 2 days over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to one day for Specialty Care.
  - Data Source: Appointment management system

- **Outcome Improvement Target 2 Estimated Incentive Payment:** $611,677

#### Year 2 Estimated Outcome Amount:
$114,689

#### Year 3 Estimated Outcome Amount:
$273,070

#### Year 4 Estimated Outcome Amount:
$283,993

#### Year 5 Estimated Outcome Amount:
$611,677

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,283,429
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 111810101.3.1
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure)
Increase the number of patients who had each of the following during the reporting period:
Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed during the measurement year.
LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
Increase by 3% the percentage of patients who had each of the following during the reporting period:
Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year) and LDL-C Level <100 mg/dL (the most recent during the measurement year)
DY5:
Increase by 5% the percentage of patients who had each of the following during the reporting period:
Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year) and LDL-C Level <100 mg/dL (the most recent during the measurement year)

Rationale:
By increasing access to specialty care, such as the expansion of cardiology care to UT Physicians primary care clinics, we expect that patients at risk for coronary artery disease (CAD) and coronary heart disease (CHD), heart attack, and stroke, are more likely to get the cholesterol screening that would facilitate appropriate care. Working together with patients with known heart disease to reduce cholesterol has the potential to reduce morbidity (heart attack and stroke) and mortality. Using established guidelines (National Cholesterol Education Program) for managing cholesterol levels in patients with heart disease, we would aim to see a reduction in LDL-C of less than or equal to 100 mg/dL.
**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
| 111810101.3.14 | 3.IT-1.6 | Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure) |
|----------------|----------|-----------------------------------------------------------------------------------------------------------------
| UTHealth, UTPhysicians | | |
| Related Category 1 or 2 Projects: | 111810101.7 | |
| Starting Point/Baseline: | | To be determined during DY3. |
| **Year 2**  
(10/1/2012 – 9/30/2013) | **Year 3**  
(10/1/2013 – 9/30/2014) | **Year 4**  
(10/1/2014 – 9/30/2015) | **Year 5**  
(10/1/2015 – 9/30/2016) |
| Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans | Process Milestone 2 [P-2]: Establish baseline rates  
Data Source: Provider reports | Outcome Improvement Target 1 [IT-1.6]: Increase by 3% the percentage of patients who had each of the following during the reporting period: Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year) and LDL-C Level <100 mg/dL (the most recent during the measurement year)  
Data Source: EMR, Claim | Outcome Improvement Target 2 [IT-1.6]: Increase by 5% the percentage of patients who had each of the following during the reporting period: Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year) and LDL-C Level <100 mg/dL (the most recent during the measurement year)  
Data Source: EMR, Claim |
| Year 2 Estimated Outcome Amount: $ 114,689 | Year 3 Estimated Outcome Amount: $ 273,070 | Year 4 Estimated Outcome Amount: $ 283,993 | Year 5 Estimated Outcome Amount: $ 611,677 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 1,283,429
Title of Outcome Measure (Improvement Target): OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions

Unique RHP outcome identification number(s): 111810101.3.15
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-4.8 Sepsis mortality (Standalone measure)
Reduce the percentage of patients expiring during current month hospitalization with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-4.8 Reduce by 3% the percentage of patients expiring during current month hospitalization with sepsis, severe sepsis, or septic shock and/or an infection and organ dysfunction.
DY5:
IT-4.8 Reduce by 5% the percentage of patients expiring during current month hospitalization with sepsis, severe sepsis, or septic shock and/or an infection and organ dysfunction.

Rationale:
Sepsis is one of the leading causes of death in the intensive care unit (ICU) (Bone RC, Balk RA, Cerra FB, Dellinger RP, Fein AM, Knaus WA, et al. Definitions for sepsis and organ failure and guidelines for the use of innovative therapies in sepsis. Chest 1992; 101:1644-55). The number of severe sepsis cases is set to grow at a rate of 1.5% per annum, adding an additional 1 million cases per year in the USA by 2020 (Angus DC, Linde-Zwirble WT, Lidicker J, Clermont G, Carcillo J, Pinsky MR. Epidemiology of severe sepsis in the United States: analysis of incidence, outcome, and associated costs of care. Crit Care Med. 2001 Jul;29(7):1303-10), mainly due to the growing use of invasive procedures and increasing numbers of elderly and high-risk individuals, such as cancer and HIV patients. Sepsis from invasive procedures can be highly reduced by greater adherence to guidelines and by addressing systemic factors that lead to breach of aseptic standards. By improving health care quality, this project will lead to reduction in hospital acquired conditions such as sepsis.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>UTHealth, UTPhysicians</th>
<th>Sepsis mortality (Standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>111810101.8</td>
<td>111810101.3.15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates. Data Source: Provider reports.</td>
<td>Outcome Improvement Target 1 [IT-4.8]: Reduce by 3% the percentage of patients expiring during current month hospitalization with sepsis, severe sepsis, or septic shock and/or an infection and organ dysfunction. Data Source: Memorial Hermann Hospital-TMC data.</td>
<td>Outcome Improvement Target 2 [IT-4.8]: Reduce by 5% the percentage of patients expiring during current month hospitalization with sepsis, severe sepsis, or septic shock and/or an infection and organ dysfunction. Data Source: Memorial Hermann Hospital-TMC data.</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 95,785</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 114,029</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 237,181</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 510,851</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 95,785</td>
<td>Year 3 Estimated Outcome Amount: $ 228,058</td>
<td>Year 4 Estimated Outcome Amount: $ 237,181</td>
<td>Year 5 Estimated Outcome Amount: $ 510,851</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 1,071,875
Title of Outcome Measure (Improvement Target): OD-6 Patient Satisfaction

Unique RHP outcome identification number(s): 111810101.3.16
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-6.1 (1) Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone measure)
Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a stand-alone measure). Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients: (1) are getting timely care, appointments, and information (already established patients at UTP Clinics, who are not cancer surgery patients and who were assigned to a medical home)

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-6.1 (1) Improve by 3% the percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information (using the supplemental module for the adult CG-CAHPS survey) for patients of UT Physician Clinics, who are not cancer surgery patients and who were assigned to a medical home.
DY5:
IT-6.1 (1) Improve by 5% the percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information (using the supplemental module for the adult CG-CAHPS survey) for patients of UT Physician Clinics, who are not cancer surgery patients and who were assigned to a medical home.

Rationale:
The medical home project will provide a primary care "home base" for patients, and they will be assigned a health care team that will effectively coordinate their care across inpatient and outpatient settings, and proactively provide preventive, primary, routine and chronic care to them. This would translate to increased likelihood of getting timely care, ease of setting up appointments and receiving helpful care information. Thus assessing patient satisfaction (for patients of UT Physician clinics, who are not cancer surgery patients and have been assigned to a medical home) in these domains of their care experience, as measured using the adult CG-CAHPS survey for the domain of getting timely care, appointments, and information, will be a good measure of the outcome of this project.
Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>111810101.3.16</th>
<th>3.IT-6.1 (1)</th>
<th>Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone measure)</th>
</tr>
</thead>
</table>

**UTHealth, UTPhysicians**

<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>111810101.2.1</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>To be determined during DY3.</th>
</tr>
</thead>
</table>

### Year 2 (10/1/2012 – 9/30/2013)

- **Process Milestone 1 [P-1]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
  Data Source: Project reports and documents
- **Process Milestone 1 Estimated Incentive Payment:** $83,182

### Year 3 (10/1/2013 – 9/30/2014)

- **Process Milestone 2 [P-2]:** Establish baseline rates  
  Data Source: Provider reports
- **Process Milestone 2 Estimated Incentive Payment:** $99,026
- **Process Milestone 3 [P-3]:** Develop and test data systems  
  Data Source: Project reports, EMR, claims
- **Process Milestone 3 Estimated Incentive Payment:** $99,025

### Year 4 (10/1/2014 – 9/30/2015)

- **Outcome Improvement Target 1 [IT-6.1 (1)]:** Improve by 3% the percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information (using the supplemental module for the adult CG-CAHPS survey) for patients of UT Physician Clinics, who are not cancer surgery patients and who were assigned to a medical home.  
  Data Source: Surveys
- **Outcome Improvement Target 1 Estimated Incentive Payment:** $205,978

### Year 5 (10/1/2015 – 9/30/2016)

- **Outcome Improvement Target 2 [IT-6.1 (1)]:** Improve by 5% the percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information (using the supplemental module for the adult CG-CAHPS survey) for patients of UT Physician Clinics, who are not cancer surgery patients and who were assigned to a medical home.  
  Data Source: Surveys
- **Outcome Improvement Target 2 Estimated Incentive Payment:** $443,633

### Year 2 Estimated Outcome Amount: $83,182

### Year 3 Estimated Outcome Amount: $198,051

### Year 4 Estimated Outcome Amount: $205,978

### Year 5 Estimated Outcome Amount: $443,633

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $930,839
**Title of Outcome Measure (Improvement Target):** OD-1- Primary Care and Chronic Disease Management

**Unique RHP outcome identification number(s):** 111810101.3.17

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**

IT-1.10 Diabetes care: HbA1c poor control (>9.0%) 233- NQF 0059 (Standalone measure).

   Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2).

**Process Milestones:**

DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3:
P-2 Establish baseline rates

P-3 Develop and test data systems

**Outcome Improvement Targets for each year:**

DY4:

IT-1.10 Decrease by 3% the percent over baseline the number of patients 18-75 years of age with diabetes (type 1 or type 2), and who were assigned to a medical home, who had hemoglobin A1c (HbA1c) control > 9.0%.

DY5:

IT-1.10 Decrease by 5% the percent over baseline the number of patients 18-75 years of age with diabetes (type 1 or type 2), and who were assigned to a medical home, who had hemoglobin A1c (HbA1c) control > 9.0%.

**Rationale:**

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars. The medical home project will provide a primary care "home base" for patients, and they will be assigned a health care team that will effectively coordinate their care across inpatient and outpatient settings, and proactively provide preventive, primary, routine and chronic care to them. This would translate to increased likelihood of getting timely care for diabetic patients, ease of setting up appointments and receiving helpful care information. Thus Assessment of HbA1c control will be a good measure of the outcome of this project.
**Outcome Measure Valuation:**

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
<td>Outcome Improvement Target 1 [IT-1.10]: Decrease by 3% the percent over baseline the number of patients 18-75 years of age with diabetes (type 1 or type 2), and who were assigned to a medical home, who had hemoglobin A1c (HbA1c) control &gt; 9.0%.</td>
<td>Outcome Improvement Target 2 [IT-1.10]: Decrease by 5% the percent over baseline the number of patients 18-75 years of age with diabetes (type 1 or type 2), and who were assigned to a medical home, who had hemoglobin A1c (HbA1c) control &gt; 9.0%.</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: EHR, Registry, Claims, Administrative clinical data.</td>
<td>Data Source: EHR, Registry, Claims, Administrative clinical data.</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 83,181</td>
<td>Year 3 Estimated Outcome Amount: $ 198,051</td>
<td>Year 4 Estimated Outcome Amount: $ 205,978</td>
<td>Year 5 Estimated Outcome Amount: $ 443,634</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 930,839
**Title of Outcome Measure (Improvement Target):** OD-2 Potentially Preventable Admissions

**Unique RHP outcome identification number(s):** 111810101.3.18

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**

**IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate:** (Standalone measure)

**Numerator:** Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (including any one most responsible diagnosis code of: Grand mal status and other epileptic convulsions, Chronic obstructive pulmonary diseases, Asthma, Heart failure and pulmonary edema, Hypertension, Angina, and Diabetes). Exclusions: Individuals 75 years of age and older, or death before discharge.

**Denominator:** Total mid-year population under age 75

**Process Milestones:**

**DY2:**

P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

**DY3:**

P-3 Develop and test data systems

P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**

**DY4:**

IT-2.11 Reduce by 3% the percentage of acute care hospitalizations for ambulatory care sensitive conditions (including any one most responsible diagnosis code of: Grand mal status and other epileptic convulsions, Chronic obstructive pulmonary diseases, Asthma, Heart failure and pulmonary edema, Hypertension, Angina, and Diabetes) for persons under the age 75 years. Exclusions: Individuals 75 years of age and older, or death before discharge.

**DY5:**

IT-2.11 Reduce by 5% the percentage of acute care hospitalizations for ambulatory care sensitive conditions (including any one most responsible diagnosis code of: Grand mal status and other epileptic convulsions, Chronic obstructive pulmonary diseases, Asthma, Heart failure and pulmonary edema, Hypertension, Angina, and Diabetes) for persons under the age 75 years. Exclusions: Individuals 75 years of age and older, or death before discharge.

**Rationale:**

This project aims to develop and implement evidence based chronic disease management interventions (Coleman et al. Evidence on the Chronic Care Model in the New Millennium. Health Affairs 28, no. 1 (2009): 75–85) that will ultimately improve patient clinical indicators, health outcomes, and reduce unnecessary acute and emergency care utilization for patients with chronic diseases. Appropriate primary care and evidence-based management of chronic diseases has the potential to reduce acute episodes of illnesses requiring hospitalization.
**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
<td>Outcome Improvement Target 1 [IT-2.11]: Reduce by 3% the percentage of acute care hospitalizations for ambulatory care sensitive conditions (including any one most responsible diagnosis code of: Grand mal status and other epileptic convulsions, Chronic obstructive pulmonary diseases, Asthma, Heart failure and pulmonary edema, Hypertension, Angina, and Diabetes) for persons under the age 75 years.</td>
<td>Outcome Improvement Target 2 [IT-2.11]: Reduce by 5% the percentage of acute care hospitalizations for ambulatory care sensitive conditions (including any one most responsible diagnosis code of: Grand mal status and other epileptic convulsions, Chronic obstructive pulmonary diseases, Asthma, Heart failure and pulmonary edema, Hypertension, Angina, and Diabetes) for persons under the age 75 years.</td>
</tr>
<tr>
<td>Data Source: Provider reports</td>
<td>Data Source: Provider reports</td>
<td>Data Source: EHR, Claims</td>
<td>Data Source: EHR, Claims</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $ 162,041</td>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 337,046</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 725,946</td>
</tr>
<tr>
<td>Data Source: Project reports, EMR, claims</td>
<td>Data Source: Project reports, EMR, claims</td>
<td>Outcome Source: EHR, Claims</td>
<td>Outcome Source: EHR, Claims</td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $ 162,042</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 337,046</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 337,046</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 725,946</td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $ 162,041</td>
<td>Process Milestone 3 Estimated Incentive Payment: $ 162,042</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 337,046</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 725,946</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 136,115</td>
<td>Year 3 Estimated Outcome Amount: $ 324,083</td>
<td>Year 4 Estimated Outcome Amount: $ 337,046</td>
<td>Year 5 Estimated Outcome Amount: $ 725,946</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 1,523,190
Title of Outcome Measure (Improvement Target): OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)

Unique RHP outcome identification number(s): 111810101.3.19
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-3.9 Chronic Obstructive Pulmonary Disease 30 day readmission rate (Standalone measure)
Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of COPD and with a complete claims history for the 12 months prior to admission.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-3.9 Reduce by 3% the percentage of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
DY5:
IT-3.9 Reduce by 5% the percentage of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

Rationale:
When a patient is discharged without optimal follow-up, it could have terrible consequences such as hospital readmission and possibly death. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
## Chronic Obstructive Pulmonary Disease 30 day readmission rate (Standalone measure)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT-3.9</td>
<td>Chronic Obstructive Pulmonary Disease 30 day readmission rate</td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:** 111810101.2.3

**Starting Point/Baseline:** To be determined during DY3.

### Year 2 (10/1/2012 – 9/30/2013)
- **Process Milestone 1 [P-1]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - **Data Source:** Project reports and documents
- **Process Milestone 1 Estimated Incentive Payment:** $151,239

### Year 3 (10/1/2013 – 9/30/2014)
- **Process Milestone 2 [P-2]:** Establish baseline rates
  - **Data Source:** Provider reports
- **Process Milestone 2 Estimated Incentive Payment:** $180,046
- **Process Milestone 3 [P-3]:** Develop and test data systems
  - **Data Source:** Project reports, EMR, claims
- **Process Milestone 3 Estimated Incentive Payment:** $180,046

### Year 4 (10/1/2014 – 9/30/2015)
- **Outcome Improvement Target 1 [IT-3.9]:** Reduce by 3% the percentage of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
  - **Data Source:** Surveys
- **Outcome Improvement Target 1 Estimated Incentive Payment:** $374,496

### Year 5 (10/1/2015 – 9/30/2016)
- **Outcome Improvement Target 2 [IT-3.9]:** Reduce by 5% the percentage of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
  - **Data Source:** Surveys
- **Outcome Improvement Target 2 Estimated Incentive Payment:** $806,607

### Year 2 Estimated Outcome Amount:
- $151,239

### Year 3 Estimated Outcome Amount:
- $360,092

### Year 4 Estimated Outcome Amount:
- $374,496

### Year 5 Estimated Outcome Amount:
- $806,607

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $1,692,434
**Title of Outcome Measure (Improvement Target):** OD-13 Palliative Care

**Unique RHP outcome identification number(s):** 111810101.3.20

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**
IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure)
Increase the number of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.
Exclusion: patients with length of stay < 1 day in palliative care or <7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

**Process Milestones:**
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
DY4:
IT-13.1 Increase by 3% the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.
Exclusion: patients with length of stay < 1 day in palliative care or <7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.
DY5:
IT-13.1 Increase by 5% the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.
Exclusion: patients with length of stay < 1 day in palliative care or <7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

**Rationale:**
Research shows that the prevalence of pain among patients with incurable illness and at the end of life is as high as 40 – 70% (Gade G, Venohr I, Conner D, et al. Impact of an inpatient palliative care team: a randomized control trial. J Palliat Med. 2008;11(2):180–190), and pain is under-recognized by clinicians and undertreated, resulting in excess suffering among these
patients. Pain screening and assessments will thus be a good measure of the quality of palliative care services provided to patients.

**Outcome Measure Valuation:**

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>UTHealth, UTPhysicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be determined during DY3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1 [P-1]:** Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- Data Source: Project reports and documents

  Process Milestone 1 Estimated Incentive Payment: $26,047

**Process Milestone 2 [P-2]:** Establish baseline rates

- Data Source: Provider reports

  Process Milestone 2 Estimated Incentive Payment: $31,008

**Process Milestone 3 [P-3]:** Develop and test data systems

- Data Source: Project reports, EMR, claims

  Process Milestone 3 Estimated Incentive Payment: $31,008

**Outcome Improvement Target 1 [IT-13.1]:** Increase by 3% the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.

- Data Source: EMR, Claims

  Outcome Improvement Target 1 Estimated Incentive Payment: $64,497

**Outcome Improvement Target 2 [IT-13.1]:** Increase by 5% the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.

- Data Source: EMR, Claims

  Outcome Improvement Target 2 Estimated Incentive Payment: $138,916

**Year 2 Estimated Outcome Amount:** $26,047

**Year 3 Estimated Outcome Amount:** $62,016

**Year 4 Estimated Outcome Amount:** $64,497

**Year 5 Estimated Outcome Amount:** $138,916

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $291,476
Title of Outcome Measure (Improvement Target): OD-13 Palliative Care

Unique RHP outcome identification number(s): 111810101.3.21
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-13.2 Treatment Preferences (NQF 1641) (Non-standalone measure)
Percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments. Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
Increase by 3% the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments. Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice.
DY5:
Increase by 5% the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments. Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice.

Rationale:
In the absence of a clear guideline for end-of-life care, care decisions are often taken by the physician/care team and this tends to be in favor of life sustaining treatments. As a result of these aggressive treatments, lots of expensive interventions are given to patients in the last few months of life with poor and questionable outcomes. Site of death accounts for significant variation in end-of-life costs; for example costs for Medicare beneficiaries who died in a hospital inpatient setting have been found to be twice those for beneficiaries who died in other settings such as their homes (Carol Raphael, Joann Ahrens, & Nicole Fowler. Financing end-of-life care in the USA. J R Soc Med. 2001 September; 94(9): 458–461). Palliative care aims to address these imbalances and it is necessary to measure the success of the project by assessing how much patient preferences are being respected.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration
year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Project reports and documents. Process Milestone 1 Estimated Incentive Payment: $26,047.</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates. Data Source: Provider reports. Process Milestone 2 Estimated Incentive Payment: $31,008.</td>
<td>Outcome Improvement Target 1 [IT-13.2]: Increase by 3% the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments. Exclusions: patients with length of stay &lt; 1 day in palliative care or &lt;7 days in hospice. Data Source: EMR, Claims. Outcome Improvement Target 1 Estimated Incentive Payment: $64,497.</td>
<td>Outcome Improvement Target 2 [IT-13.2]: Increase by 5% the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments. Exclusions: patients with length of stay &lt; 1 day in palliative care or &lt;7 days in hospice. Data Source: EMR, Claims. Outcome Improvement Target 2 Estimated Incentive Payment: $138,916.</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $26,047</td>
<td>Year 3 Estimated Outcome Amount: $62,016</td>
<td>Year 4 Estimated Outcome Amount: $64,497</td>
<td>Year 5 Estimated Outcome Amount: $138,916</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $291,476
Title of Outcome Measure (Improvement Target): OD-13 Palliative Care

Unique RHP outcome identification number(s): 111810101.3.22
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-st Increase the number of patients discharged from hospice or palliative care with clinical record documentation of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
Increase by 3% the percentage of patients discharged from hospice or palliative care with clinical record documentation of discussion of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period.
DY5:
Increase by 5% the percentage of patients discharged from hospice or palliative care with clinical record documentation of discussion of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period.

Rationale:
A comprehensive interdisciplinary approach is one of the hallmarks of palliative care, and this entails caring for the physical, psychosocial, and spiritual needs of patients and their families. An essential step to providing for the needs of patients is initiating discussions about their spiritual concerns. This measure will thus be an important indicator of the quality of palliative care provided through this project.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-st)</th>
<th>UTHealth, UTPhysicians</th>
</tr>
</thead>
</table>

**Related Category 1 or 2 Projects:**

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>To be determined during DY3.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
<td>Outcome Improvement Target 1 [IT-13.5]: Increase by 3% the percentage of patients discharged from hospice or palliative care with clinical record documentation of discussion of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period.</td>
<td>Outcome Improvement Target 2 [IT-13.5]: Increase by 5% the percentage of patients discharged from hospice or palliative care with clinical record documentation of discussion of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period.</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: EMR, Claims</td>
<td>Data Source: EMR, Claims</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 26,047</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 31,008</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 64,497</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 138,916</td>
</tr>
<tr>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
<td>Data Source: Project reports, EMR, claims</td>
<td>Process Milestone 3 Estimated Incentive Payment: $ 31,008</td>
<td>Year 2 Estimated Outcome Amount: $ 26,047</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 26,047</td>
<td>Year 3 Estimated Outcome Amount: $ 62,016</td>
<td>Year 4 Estimated Outcome Amount: $ 64,497</td>
<td>Year 5 Estimated Outcome Amount: $ 138,916</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 291,476
**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease Management

**Unique RHP outcome identification number(s):** 111810101.3.23

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**
IT-1.2 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)219–angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non-standalone measure)
Percentage of members 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

**Process Milestones:**
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
DY4:
IT-1.2 Improve by 3% the percentage of members 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.
DY5:
IT-1.2 Improve by 5% the percentage of members 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

**Rationale:**
The medication management program is aimed to decrease medication errors and improve compliance with therapy especially in chronic care and in patients with multiple chronic conditions, thereby leading to improved outcomes. Because of the potential for interaction between angiotensins and digoxin and diuretics, among other medications, monitoring of patients on angiotensins will be a good measure of this project’s success.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration
year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>111810101.3.23</th>
<th>3.IT-1.2</th>
<th>Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) 219– angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non-standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UTHealth, UT Physicians</strong></td>
<td>111810101</td>
<td></td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:** 111810101.2.5

**Starting Point/Baseline:** To be determined during DY3.

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents</strong></td>
<td><strong>Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports</strong></td>
<td><strong>Outcome Improvement Target 1 [IT-1.2]: Improve by 3% the percentage of members 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: EMR, Claims</strong></td>
<td><strong>Outcome Improvement Target 2 [IT-1.2]: Improve by 5% the percentage of members 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Data Source: EMR, Claims</strong></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 28,567</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 34,008</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 70,738</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 152,359</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount: $ 28,567</strong></td>
<td><strong>Year 3 Estimated Outcome Amount: $ 68,017</strong></td>
<td><strong>Year 4 Estimated Outcome Amount: $ 70,738</strong></td>
<td><strong>Year 5 Estimated Outcome Amount: $ 152,359</strong></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 319,681

Regional Healthcare Partnership Plan
Region 3

2607
**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease Management

**Unique RHP outcome identification number(s):** 111810101.3.24

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**
IT-1.3 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – digoxin (Non-standalone)
Percentage of members 18 years of age and older who received at least 180 treatment days of digoxin during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

**Process Milestones:**

**DY2:**
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

**DY3:**
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**

**DY4:**
Improve by 3% the percentage of members 18 years of age and older who received at least 180 treatment days of digoxin during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

**DY5:**
Improve by 5% the percentage of members 18 years of age and older who received at least 180 treatment days of digoxin during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

**Rationale:**
The medication management program is aimed to decrease medication errors and improve compliance with therapy especially in chronic care and in patients with multiple chronic conditions, thereby leading to improved outcomes. Because of the potential for interaction between digoxin and angiotensins, among other medications, monitoring of patients on digoxin will be a good measure of this project’s success.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration
year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>111810101.3.24</th>
<th>3.IT-1.3</th>
<th>Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012) – digoxin (Non-standalone)</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTHealth, UTPhysicians</td>
<td>111810101</td>
<td>111810101.2.5</td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:**

To be determined during DY3.

<table>
<thead>
<tr>
<th>Year</th>
<th>Starting Point/Baseline</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1 [P-1]: Project planning</strong></td>
<td><strong>Process Milestone 2 [P-2]: Establish baseline rates</strong></td>
<td><strong>Outcome Improvement Target 1 [IT-1.3]: Improve by 3% the percentage of members 18 years of age and older who received at least 180 treatment days of digoxin during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.</strong></td>
<td><strong>Outcome Improvement Target 2 [IT-1.3]: Improve by 5% the percentage of members 18 years of age and older who received at least 180 treatment days of digoxin during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: EMR, Claims</td>
<td>Data Source: EMR, Claims</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 28,567</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 34,008</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 70,738</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 152,359</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 28,567</td>
<td>Year 3 Estimated Outcome Amount: $ 68,017</td>
<td>Year 4 Estimated Outcome Amount: $ 70,738</td>
<td>Year 5 Estimated Outcome Amount: $ 152,359</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 319,681
**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease Management

**Unique RHP outcome identification number(s):** 111810101.3.25

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**
IT-1.4 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)– diuretic (Non- standalone measure)
Percentage of members 18 years of age and older who received at least 180 treatment days of a diuretic during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

**Process Milestones:**
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
DY4:
Improve by 3% the percentage of members 18 years of age and older who received at least 180 treatment days of a diuretic during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.
DY5:
Improve by 5% the percentage of members 18 years of age and older who received at least 180 treatment days of a diuretic during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

**Rationale:**
The medication management program is aimed to decrease medication errors and improve compliance with therapy especially in chronic care and in patients with multiple chronic conditions, thereby leading to improved outcomes. Because of the potential for interaction between diuretics and angiotensins, among other medications, monitoring of patients on diuretics will be a good measure of this project’s success.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration
year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Process Milestone 2 [P-2]: Establish baseline rates</th>
<th>Outcome Improvement Target 1 [IT-1.4]: Improve by 3% the percentage of members 18 years of age and older who received at least 180 treatment days of a diuretic during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.</th>
<th>Outcome Improvement Target 2 [IT-1.4]: Improve by 5% the percentage of members 18 years of age and older who received at least 180 treatment days of a diuretic during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: EMR, Claims</td>
<td>Data Source: EMR, Claims</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 28,567</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 34,008</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 70,738</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 152,359</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 28,567</td>
<td>Year 3 Estimated Outcome Amount: $ 68,017</td>
<td>Year 4 Estimated Outcome Amount: $ 70,738</td>
<td>Year 5 Estimated Outcome Amount: $ 152,359</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 319,681
**Title of Outcome Measure (Improvement Target):** OD-3 Potentially Preventable Readmissions - 30 day Readmission Rates (PPRs)

**Unique RHP outcome identification number(s):** 111810101.3.26

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**
IT-3.3 Diabetes 30 day readmission rate (Standalone measure)
Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.

**Process Milestones:**
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
DY4:
IT-3.3 Reduce by 3% the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission.
DY5:
IT-3.3 Reduce by 5% the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission.

**Rationale:**
When a patient is discharged without optimal follow-up, it could have terrible consequences such as hospital readmission and possibly death. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays. Also, patients with cancer often have to consult with different kinds of providers at different settings as part of their care process - ranging from inpatient surgical procedures, outpatient clinic settings, to appointment for procedures/therapies such as radiotherapy. By providing assistance in transitioning from hospital care to out-patient care, we expect that hospital readmission rates would go down.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>111810101.3.26</th>
<th>3.IT-6.1 (1)</th>
<th>Percent improvement over baseline of patient satisfaction scores: (1) are getting timely care, appointments, and information (Standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Related Category 1 or 2 Projects:</strong></td>
<td><strong>111810101.2.6</strong></td>
<td><strong>111810101</strong></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>To be determined during DY3.</strong></td>
<td><strong>To be determined during DY3.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Process Milestone 1 [P-1]: Project planning - engage stakeholders,** **identify current capacity and needed resources,** **determine timelines and document implementation plans** | **Process Milestone 2 [P-2]: Establish baseline rates**  
**Data Source:** Provider reports | **Outcome Improvement Target 1 [IT-3.3] Reduce by 3% the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission.**  
**Data Source:** EMRs | **Outcome Improvement Target 2 [IT-3.3] Reduce by 5% the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission.**  
**Data Source:** EMRs |
| **Process Milestone 1 Estimated Incentive Payment:** $ 141,156 | **Process Milestone 2 Estimated Incentive Payment:** $ 168,043 | **Outcome Improvement Target 1 Estimated Incentive Payment:** $ 349,530 | **Outcome Improvement Target 2 Estimated Incentive Payment:** $ 752,833 |
| **Year 2 Estimated Outcome Amount:** $ 141,156 | **Year 3 Estimated Outcome Amount:** $ 336,086 | **Year 4 Estimated Outcome Amount:** $ 349,530 | **Year 5 Estimated Outcome Amount:** $ 752,833 |

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 1,579,605
**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease Management

**Unique RHP outcome identification number(s):** 111810101.3.27  
**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**  
IT-1.8 Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) (Non-standalone measure)  
**Numerator:** Patient’s screening for clinical depression using a standardized tool AND follow-up plan is documented.

**Process Milestones:**  
DY2:  
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
DY3:  
P-3 Develop and test data systems  
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**  
DY4:  
IT-1.8 Increase by 3% the percentage of UT Physicians patients who receive screening for clinical depression using a standardized tool AND a follow-up plan is documented.  
DY5:  
IT-1.8 Increase by 5% the percentage of UT Physicians patients who receive screening for clinical depression using a standardized tool AND a follow-up plan is documented.

**Rationale:**  
The integration of behavioral health care with primary health care is expected to increase the detection and treatment of depression. When depression is recognized, it can be appropriately treated and outcomes improved, particularly when coupled with primary care. Systematic screening is a means of improving detection, treatment, and outcomes of depression. Therefore measuring screening rates and treatment plans will be an appropriate measure of the success of this project for integrating behavioral health care and primary health care.

**Outcome Measure Valuation:**  
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Project reports and documents</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 78,140</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process Milestone 2 [P-2]: Establish baseline rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Provider reports</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $ 93,024</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process Milestone 3 [P-3]: Develop and test data systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Project reports, EMR, claims</td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $ 93,024</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Improvement Target 1 [IT-1.8]: Increase by 3% the percentage of UT Physicians patients who receive screening for clinical depression using a standardized tool AND a follow-up plan is documented.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: EMR, claims</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 193,490</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Improvement Target 2 [IT-1.8]: Increase by 5% the percentage of UT Physicians patients who receive screening for clinical depression using a standardized tool AND a follow-up plan is documented.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: EMR, claims</td>
</tr>
<tr>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 416,747</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount: $ 78,140</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 3 Estimated Outcome Amount: $ 186,048</td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount: $ 193,490</td>
</tr>
<tr>
<td>Year 5 Estimated Outcome Amount: $ 416,747</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 874,425
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 111810101.3.28
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-1.9 Depression management: Depression Remission at Twelve Months (NQF# 0710) (Standalone measure)
Numerator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.
Denominator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine.
Exclusions: Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
Increase by 3% the percentage of adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.
DY5:
Increase by 5% the percentage of adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.

Rationale:
The Patient Health Questionnaire (PHQ-9) tool is a widely accepted and standardized tool that is utilized by providers to monitor treatment progress. There is evidence that integrated behavioral health services enhance access to mental health care services, improve quality of life, reduce the incidence of depression and utilization of emergency department services, and overall health care costs (AHRQ. Service Delivery Innovation Profile: Integrated Behavioral Health Reduces Depression and Anxiety in Primary Care Patients, Improving Quality of Life and Reducing Costs. http://www.innovations.ahrq.gov/content.aspx?id=2951). Assessment of depression remission will thus be suitable to assess the success of this integrated care project.
Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>111810101.3.28</th>
<th>3.IT-1.9</th>
<th>Depression management: Depression Remission at Twelve Months (NQF# 0710) (Standalone measure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTHealth, UTPhysicians</td>
<td>111810101.2.7</td>
<td>111810101</td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:**

**Starting Point/Baseline:**

- To be determined during DY3.

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 1 Estimated Incentive Payment: $78,140</td>
<td>Outcome Improvement Target 1 [IT-1.9]: Increase by 3% the percentage of adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/-30 days) PHQ-9 score of less than five.</td>
<td>Outcome Improvement Target 2 [IT-1.9]: Increase by 5% the percentage of adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/-30 days) PHQ-9 score of less than five.</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
<td>Data Source: Provider reports</td>
<td>Data Source: Electronic Clinical Data, Electronic Health Record, Paper Records</td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $93,024</td>
<td>Process Milestone 2 Estimated Incentive Payment: $93,024</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $193,490</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $416,747</td>
</tr>
<tr>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
<td>Process Milestone 3 Estimated Incentive Payment: $93,024</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $193,490</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $416,747</td>
</tr>
<tr>
<td>Data Source: Project reports, EMR, claims</td>
<td>Data Source: Electronic Clinical Data, Electronic Health Record, Paper Records</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $193,490</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $416,747</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $78,140</td>
<td>Year 3 Estimated Outcome Amount: $186,048</td>
<td>Year 4 Estimated Outcome Amount: $193,490</td>
<td>Year 5 Estimated Outcome Amount: $416,747</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $874,425
The University of Texas Health Science Center - Houston
Pass 2
**Title of Outcome Measure (Improvement Target):** OD-12 Primary Care and Primary Prevention

**Unique RHP outcome identification number(s):** 111810101.3.29

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**
IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)
   Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period. Denominator: Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded.

**Process Milestones:**
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
DY4:
IT-12.1 Increase by 3% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded.
DY5:
IT-12.1 Increase by 5% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded.

**Rationale:**
By increasing primary care capacity, preventative care and recommended screenings to detect cancer early would be available to more people in the community. By screening for early stages of disease before symptoms occur, patients testing positive can receive appropriate follow-up diagnostic tests, treatment, and follow-up. Early detection may reduce the impact of cancer when treatment may be easier and more effective than for an advanced cancer diagnosis in terms of the disease burden, harm and cost. Along with additional physicians to see patients for primary care, the extended hours would make it more convenient for patients to get these early screening tests.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Year</th>
<th>Process Milestone</th>
<th>Data Source</th>
<th>Estimated Incentive Payment</th>
<th>Outcome Improvement Target</th>
<th>Data Source</th>
<th>Estimated Incentive Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>[P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Project reports and documents</td>
<td>$71,122</td>
<td>Outcome Improvement Target 1 [IT-12.1]: Increase by 3% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded.</td>
<td>EHR, Claims</td>
<td>$182,352</td>
</tr>
<tr>
<td>3</td>
<td>[P-2]: Establish baseline rates</td>
<td>Provider reports</td>
<td>$84,255</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>[P-3]: Develop and test data systems</td>
<td>Project reports, EMR, claims</td>
<td>$84,255</td>
<td>Outcome Improvement Target 2 [IT-12.1]: Increase by 5% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded.</td>
<td>EHR, Claims</td>
<td>$395,016</td>
</tr>
<tr>
<td>2</td>
<td>Estimated Outcome Amount:</td>
<td>$71,122</td>
<td>Year 3 Estimated Outcome Amount:</td>
<td>$168,510</td>
<td>Year 4 Estimated Outcome Amount:</td>
<td>$182,352</td>
</tr>
<tr>
<td>3</td>
<td>Estimated Outcome Amount:</td>
<td>$84,255</td>
<td>Year 4 Estimated Outcome Amount:</td>
<td>$182,352</td>
<td>Year 5 Estimated Outcome Amount:</td>
<td>$395,016</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $817,000
**Title of Outcome Measure (Improvement Target):** OD-12 Primary Care and Primary Prevention

**Unique RHP outcome identification number(s):** 111810101.3.30

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**
IT-12.2 Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)
- **Numerator:** Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. Denominator: Women aged 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix are excluded.

**Process Milestones:**
- **DY2:** P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- **DY3:** P-3 Develop and test data systems
- **DY2:** P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
- **DY4:** IT-12.2 Increase by 3% the percentage of women patients of UT Physicians aged 21 to 64 that have received a PAP in the measurement year or two prior years. Women who have had a complete hysterectomy with no residual cervix are excluded.
- **DY5:** IT-12.2 Increase by 5% the percentage of women patients of UT Physicians aged 21 to 64 that have received a PAP in the measurement year or two prior years. Women who have had a complete hysterectomy with no residual cervix are excluded.

**Rationale:**
By increasing primary care capacity, preventative care and recommended screenings to detect cancer early would be available to more people in the community. By screening for early stages of disease before symptoms occur, patients testing positive can receive appropriate follow-up diagnostic tests, treatment, and follow-up. Early detection may reduce the impact of cancer when treatment may be easier and more effective than for an advanced cancer diagnosis in terms of the disease burden, harm and cost. Along with additional physicians to see patients for primary care, the extended hours would make it more convenient for patients to get these early screening tests.

**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>111810101.9</th>
<th>Role: UTHealth, UTPhysicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>111810101.3.30</td>
<td>Cervical Cancer Screening (HEDIS 2012) (Non-standalone measure)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
<td>Outcome Improvement Target 1 [IT-12.2] Increase by 3% the percentage of women patients of UT Physicians aged 21 to 64 that have received a PAP in the measurement year or two prior years. Women who have had a complete hysterectomy with no residual cervix are excluded.</td>
<td>Outcome Improvement Target 2 [IT-12.2] Increase by 5% the percentage of women patients of UT Physicians aged 21 to 64 that have received a PAP in the measurement year or two prior years. Women who have had a complete hysterectomy with no residual cervix are excluded.</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: EMR</td>
<td>Data Source: EMR</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 71,123</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 84,256</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 182,353</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 395,017</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 71,123</td>
<td>Year 3 Estimated Outcome Amount: $ 168,512</td>
<td>Year 4 Estimated Outcome Amount: $ 182,353</td>
<td>Year 5 Estimated Outcome Amount: $ 395,017</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 817,005
**Title of Outcome Measure (Improvement Target):** OD-12 Primary Care and Primary Prevention

**Unique RHP outcome identification number(s):** 111810101.3.31

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**
IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)

   Numerator: Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years

   Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.

**Process Milestones:**

DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3:
P-3 Develop and test data systems

P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**

DY4:
IT-12.3 Increase by 3% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded.

DY5:
IT-12.3 Increase by 5% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded.

**Rationale:**

By increasing primary care capacity, preventative care and recommended screenings to detect cancer early would be available to more people in the community. By screening for early stages of disease before symptoms occur, patients testing positive can receive appropriate follow-up diagnostic tests, treatment, and follow-up. Early detection may reduce the impact of cancer when treatment may be easier and more effective than for an advanced cancer diagnosis in terms of the disease burden, harm and cost. Along with additional physicians to see patients for primary care, the extended hours would make it more convenient for patients to get these early screening tests.
Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>111810101.3.31</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)</td>
<td>3.IT-12.3</td>
</tr>
<tr>
<td>UTHealth, UTPhysicians</td>
<td>111810101.1.9</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be determined during DY3.</td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 71,123</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 84,256</td>
</tr>
<tr>
<td></td>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
</tr>
<tr>
<td></td>
<td>Data Source: Project reports, EMR, claims</td>
</tr>
<tr>
<td></td>
<td>Process Milestone 3 Estimated Incentive Payment: $ 84,255</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td>Year 3 Estimated Outcome Amount:</td>
</tr>
<tr>
<td>$ 71,123</td>
<td>$ 168,511</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $ 817,004
**Title of Outcome Measure (Improvement Target):** OD-1 Primary Care and Chronic Disease Management

**Unique RHP outcome identification number(s):** 111810101.3.32

**Performing Provider Name/TPI:** UTHealth, UTPhysicians/111810101

**Outcome Measure Description:**
IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure)
Increase the number of patients who had each of the following during the reporting period:
Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed during the measurement year.
LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL.

**Process Milestones:**
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

**Outcome Improvement Targets for each year:**
DY4:
Increase by 3% the percentage of patients who had each of the following during the reporting period:
Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year) and LDL-C Level <100 mg/dL (the most recent during the measurement year)
DY5:
Increase by 5% the percentage of patients who had each of the following during the reporting period:
Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year) and LDL-C Level <100 mg/dL (the most recent during the measurement year)

**Rationale:**
By increasing access to specialty care, such as the expansion of cardiology care to UT Physicians primary care clinics, we expect that patients at risk for coronary artery disease (CAD) and coronary heart disease (CHD), heart attack, and stroke, are more likely to get the cholesterol screening that would facilitate appropriate care. Working together with patients with known heart disease to reduce cholesterol has the potential to reduce morbidity (heart attack and stroke) and mortality. Using established guidelines (National Cholesterol Education Program) for managing cholesterol levels in patients with heart disease, we would aim to see a reduction in LDL-C of less than or equal to 100 mg/dL.
**Outcome Measure Valuation:**
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.
### Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure)

**UTHealth, UTPhysicians**

**Related Category 1 or 2 Projects:**

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>111810101.1.10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $66,458</td>
<td>Process Milestone 2 Estimated Incentive Payment: $78,730</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome Improvement Target 1 [IT-1.6]: Increase by 3% the percentage of patients who had each of the following during the reporting period: Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year) and LDL-C Level &lt;100 mg/dL (the most recent during the measurement year)</td>
<td>Outcome Improvement Target 2 [IT-1.6]: Increase by 5% the percentage of patients who had each of the following during the reporting period: Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year) and LDL-C Level &lt;100 mg/dL (the most recent during the measurement year)</td>
</tr>
<tr>
<td>Data Source: EMR, Claim</td>
<td>Data Source: EMR, Claim</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $170,397</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $369,114</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount: $66,458</th>
<th>Year 3 Estimated Outcome Amount: $157,460</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 4 Estimated Outcome Amount: $170,397</td>
<td>Year 5 Estimated Outcome Amount: $369,114</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD:** $763,429
The University of Texas Health Science Center - Houston
Pass 3
Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 111810101.3.33
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-10.1 Quality of Life (Standalone measure)
Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.
Percent of pediatric patients ages 8-18, who are receiving both behavioral health and primary care in the integrated behavioral/primary care clinic setting for the previous 12 months, that show improvement in scores on the 23-item PedsQL™ Generic Core questionnaire.
Numerator: Patients from the denominator with improvement in scores on the 23-item PedsQL™ Generic Core questionnaire. Denominator: Patients 8-18 years of age as of the measurement year who received at least 12 months consecutive outpatient care for behavioral and primary care in the integrated clinic.

Process Milestones:
DY2: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3: P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4: IT-10.1 Increase by 3% over baseline the number of patients ages 8-18, who are receiving both behavioral health and primary care in the integrated behavioral/primary care clinic setting for the previous 12 months, that show improvement in scores on the 23-item PedsQL™ Generic Core questionnaire.
DY5: IT-10.1 Increase by 5% over baseline the number of patients ages 8-18, who are receiving both behavioral health and primary care in the integrated behavioral/primary care clinic setting for the previous 12 months, that show improvement in scores on the 23-item PedsQL™ Generic Core questionnaire.

Rationale:
In medical outcomes research, there is an increasing interest in instruments that measure health-related quality of life (HRQOL), a multidimensional concept that includes physical, psychological and social domains of health and is generally accepted as an important outcome
measure of health care.\textsuperscript{1} For a project that integrates behavioral health care with primary care, measuring HRQOL would be a particularly relevant and appropriate measure. The PedsQL\textsuperscript{TM} measurement model for pediatric quality of life can be used in both health children/adolescents and those with chronic health conditions and integrates both the generic core scales and disease-specific modules into one measurement system. This measurement model provides for multidimensional assessment that includes physical, emotional, social, and school functioning.

The PedsQL\textsuperscript{TM} has good reliability and validity and been used in numerous clinical trials, with results reported in over 700 publications.\textsuperscript{2} The generic core scales consists of 4 multidimensional scales (physical functioning-8 items, emotional functioning-5 items, social functioning-5 items, and school functioning 5-items) and 3 summary scores (physical health summary score-8 items, psychosocial health summary score-15 items, and the total scale score of all 23 items).\textsuperscript{3} The questionnaire will be administered in the clinic setting according to prescribed protocols for the administration of this questionnaire to children and their parents prior to seeing the provider for the first time.\textsuperscript{4} Follow-up questionnaires will be administered at 6 month intervals.

**Outcome Measure Valuation:**

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects’ related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.


<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>111810101.2.8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>To be determined during DY3 (new program).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 2 [P-2]: Establish baseline rates</td>
<td>Outcome Improvement Target 1 [IT-10.1]: Increase by 3% over baseline the number of patients ages 8-18, who are receiving both behavioral health and primary care in the integrated behavioral/primary care clinic setting for the previous 12 months, that show improvement in scores on the 23-item PedsQLTM Generic Core questionnaire.</td>
<td>Outcome Improvement Target 2 [IT-10.1]: Increase by 5% over baseline the number of patients ages 8-18, who are receiving both behavioral health and primary care in the integrated behavioral/primary care clinic setting for the previous 12 months, that show improvement in scores on the 23-item PedsQLTM Generic Core questionnaire.</td>
</tr>
<tr>
<td>Data Source: Project reports and documents</td>
<td>Data Source: Provider reports</td>
<td>Data Source: Patient survey</td>
<td>Data Source: Patient survey</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $ 195,350</td>
<td>Process Milestone 2 Estimated Incentive Payment: $ 232,560</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 483,724</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 1,041,867</td>
</tr>
<tr>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $ 483,724</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $ 1,041,867</td>
</tr>
<tr>
<td>Data Source: Project reports, EMR, claims</td>
<td>Data Source: Project reports, EMR, claims</td>
<td>Data Source: Patient survey</td>
<td>Data Source: Patient survey</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $ 195,350</td>
<td>Year 3 Estimated Outcome Amount: $ 465,119</td>
<td>Year 4 Estimated Outcome Amount: $ 483,724</td>
<td>Year 5 Estimated Outcome Amount: $ 1,041,867</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 2,186,060
Tomball Regional Hospital
Pass 1
Performing Provider Name/TPI: Tomball Regional Medical Center / 288523801

Title of Outcome Measure (Improvement Target): OD-2- Potentially Preventable Admissions

Title of Outcome Measure (Improvement Target): IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate- 241PQI 5 (Stand alone measure)

a. Numerator: All non-maternal discharges of age 18 years and older with a principal diagnosis code for COPD.
b. Denominator: Population in Metro Area or county, age 18 years and older.
c. Data Source: EHR, Claims
d. Rationale/Evidence: COPD with MCC is the fourth largest admission category for the target population in Tomball. Combined with all COPD cases in this population group the diagnosis creates four admissions per month. Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion.

The above targets were chose due to the fact that these diagnoses represent the two largest groups of preventable admissions in Tomball. By providing access to care, patients can receive treatment in a timely fashion and therefore prevent the escalation of illness to the point of requiring hospital services. The targeted reduction of five percent of these admissions would reduce state payments for hospital services and uncompensated care by $265,000 annually for each Improvement Target.

To achieve these targets, a planning group will be formed to include Pulmonologists, ED providers, Family Practice Physician, the clinic Mid-Level provider and representatives of the Clinic and Hospital Administrative teams. This group will be tasked to identify proper clinical protocols, patient education material, other needed resources and to document implementation plans.

Valuation is based on the potential savings of admissions and the providers’ time to develop the program.

241http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V41/TechSpecs/PQI%2005%20Chronic%20Obs\r\ntructive%20Pulmonary%20Disease%20(COPD)%20Admission%20Rate.pdf
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Implementation Plan</td>
<td>Process Milestone 2 [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td>Outcome Improvement Target 2 [IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate- 241PQI 5 (Standalone measure)]</td>
<td>Outcome Improvement Target 3 [IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate- 241PQI 5 (Standalone measure)]</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $31,726</td>
<td>Data Source: Plan Documentation</td>
<td>a Numerator: All non-maternal discharges of age 18 years and older with a principal diagnosis code for COPD. b Denominator: Population in Metro Area or county, age 18 years and older. c Data Source: EHR, Claims</td>
<td>a Numerator: All non-maternal discharges of age 18 years and older with a principal diagnosis code for COPD. b Denominator: Population in Metro Area or county, age 18 years and older. c Data Source: EHR, Claims</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td>Process Milestone 3 Estimated Incentive Payment: $31,726</td>
<td>Outcome Improvement Target 4% Estimated Incentive Payment: $212,000</td>
<td>Outcome Improvement Target 5% Estimated Incentive Payment: $265,000</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target 1 IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate- 241PQI 5 (Standalone measure)</td>
<td>a Numerator: All non-maternal discharges of age 18 years and older with a principal diagnosis code for COPD. b Denominator: Population in Metro Area or county, age 18 years and older. c Data Source: EHR, Claims[IT-1.1]:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Related Category 1 or 2 Projects:

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome Improvement Target 1 2%</strong></td>
<td><strong>Estimated Incentive Payment:</strong> $106,000</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> $212,000</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $265,000</td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong> $31,726</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> $137,726</td>
<td><strong>Year 5 Estimated Outcome Amount:</strong> $265,000</td>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):</strong> $646,452</td>
</tr>
</tbody>
</table>

**Regional Healthcare Partnership Plan**

Region 3
**Unique ID:** 288523801.3.2  
**Performing Provider Name/TPI:** Tomball Regional Medical Center / 288523801

**Title of Outcome Measure (Improvement Target):** IT-2.10 Flu and pneumonia Admission Rate *(Stand alone measure)*  

a. Numerator: All discharges of age 18 years and older with a principal diagnosis code of flu or pneumonia.  
b. Denominator: Population in Metro Area or county, age 18 years and older.  
c. Data Source: EHR, Claims  
d. Rationale/Evidence: Hospitalizations for the Bacterial Pneumonia are considered “potentially preventable,” because if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred. The methodology used to identify “potentially preventable hospitalizations” was developed by the Agency for Healthcare Research and Quality (AHRQ). AHRQ is the lead federal agency responsible for research on healthcare quality costs, outcomes and patient safety.

The above targets were chose due to the fact that these diagnoses represent the two largest groups of preventable admissions in Tomball. By providing access to care, patients can receive treatment in a timely fashion and therefore prevent the escalation of illness to the point of requiring hospital services. The targeted reduction of five percent of these admissions would reduce state payments for hospital services and uncompensated care by $265,000 annually for each Improvement Target.

To achieve these targets, a planning group will be formed to include Pulmonologists, ED providers, Family Practice Physician, the clinic Mid-Level provider and representatives of the Clinic and Hospital Administrative teams. This group will be tasked to identify proper clinical protocols, patient education material, other needed resources and to document implementation plans.

Valuation is based on the potential savings of admissions and the providers’ time to develop the program.

http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V41/TechSpecs/PQI%2005%20Chronic%20Obstuitive%20Pulmonary%20Disease%20(COPD)%20Admission%20Rate.pdf
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong> <a href="#">RHP PP</a> <strong>Process Milestone – P-1</strong>: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 2</strong> [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</td>
<td><strong>Outcome Improvement Target 2</strong> IT-2.10 Flu and pneumonia Admission Rate <em>(Standalone measure)</em> Data Source: EHR, Claims Outcome Improvement Target 2: 25 fewer uninsured or Medicaid inpatient admissions from Tomball zip codes, Estimated Incentive Payment: $212,000</td>
<td><strong>Outcome Improvement Target 3</strong> IT-2.10 Flu and pneumonia Admission Rate <em>(Standalone measure)</em> Data Source: EHR, Claims Outcome Improvement Target 3: 35 fewer uninsured or Medicaid inpatient admissions from Tomball zip codes, Estimated Incentive Payment: $265,000</td>
</tr>
<tr>
<td>Data Source: Implementation Plan</td>
<td>Data Source: Plan Documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment <em>(maximum amount)</em>: $ 31,726</td>
<td>Process Milestone 2 Estimated Incentive Payment: $45,909</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 3</strong> [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $45,909</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target 1</strong> IT-2.10 Flu and pneumonia Admission Rate <em>(Standalone measure)</em> Data Source: EHR, Claims Outcome Improvement Target 1: 5 fewer uninsured or Medicaid inpatient admissions from Tomball zip codes, Estimated Incentive Payment: $ 45,909</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>288523801.1.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 31,726</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td>Year 3 Estimated Outcome Amount: $ 137,726</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
<td>Year 4 Estimated Outcome Amount: $ 212,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong>&lt;br&gt;(10/1/2015 – 9/30/2016)</td>
<td>Year 5 Estimated Outcome Amount: $ 265,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**<br>(add outcome amounts over DYs 2-5): $ 646,452
**Unique ID:** 288523801.3.3
**Performing Provider Name/TPI:** Tomball Regional Medical Center / 288523801

**Title of Outcome Measure (Improvement Target):** OD-3 Potentially Preventable Re-Admissions - 30-day Readmission Rates (PPRs)

**Outcome Measure Description:**

The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. Given data limitations, only readmissions to the same facility will be included as part of each hospital’s rates.

Readmission rates are calculated for the following individual medical conditions: Congestive heart failure, diabetes, chronic obstructive pulmonary disease, stroke, and asthma. Readmissions create excessive healthcare cost to providers and payers. In addition, the extended recovery period places that patient at undue risk and reduces the quality of life.

With the increased access to primary care, patients will receive post hospital follow-up and educations. Recovery and progress will be monitored and treatment plans can be amended to fit the patient’s condition.

**Title of Outcome Measure (Improvement Target):** IT-3.1 All cause 30-day readmission rate-NQF 1789250 (Stand alone measure)

a. Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned.

b. Denominator: Admissions to acute care facilities for patients aged 18 years or older.

c. Data Source: EHR, Claims

A planning group will also be convened to develop the plans and monitor the progress of this initiative. For this project data will have to be defined, baselines determined and goals established. Target improvement by year 5 is a 5% reduction in the defined diagnostic groups. Estimated savings to patients and payers is projected to reach $265,000 by DY 5.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>
| **Process Milestone 1 [RHP PP Process Milestone – P-1]**: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans | **Process Milestone 3 [P-4]**: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities | IT-3.1 All cause 30 day readmission rate- NQF 1789250 *(Standalone measure)*

a Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned.

b Denominator: Admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups.

c Data Source: EHR, Claims

Outcome Improvement Target 4%
Estimated Incentive Payment: $212,000 | IT-3.1 All cause 30 day readmission rate- NQF 1789250 *(Standalone measure)*

a Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned.

b Denominator: Admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups.

c Data Source: EHR, Claims

Outcome Improvement Target 4%
Estimated Incentive Payment: $265,000 |
| **Data Source: Implementation Plan** | **Process Milestone 3 Estimated Incentive Payment:** $31,726 | **Process Milestone 3 Estimated Incentive Payment:** $31,726 | **Process Milestone 3 Estimated Incentive Payment:** $31,726 |
| **Process Milestone 1 Estimated Incentive Payment (maximum amount):** $ 31,726 | **Process Milestone 3 Estimated Incentive Payment:** $31,726 | **Process Milestone 3 Estimated Incentive Payment:** $31,726 | **Process Milestone 3 Estimated Incentive Payment:** $31,726 |
| **Process Milestone P- 2 Establish baseline rates** | **Data Source:** Plan Documentation | **Data Source:** Plan Documentation | **Data Source:** Plan Documentation |
| **Data Source:** To be Determined | **IT-3.1 All cause 30 day readmission rate- NQF 1789250 *(Standalone measure)***

*Outcome Improvement Target 4%
Estimated Incentive Payment:** $212,000 | **Outcome Improvement Target 4%
Estimated Incentive Payment:** $265,000 |
| **Process Milestone 2 Estimated Incentive Payment:** $31,726 | **Outcome Improvement Target 4%
Estimated Incentive Payment:** $212,000 | **Outcome Improvement Target 4%
Estimated Incentive Payment:** $265,000 | **Outcome Improvement Target 4%
Estimated Incentive Payment:** $265,000 |
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>288523801.1.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td></td>
</tr>
<tr>
<td>b Denominator: Admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups.</td>
<td></td>
</tr>
<tr>
<td>c Data Source: EHR, Claims</td>
<td></td>
</tr>
<tr>
<td>Outcome Improvement Target: 2%</td>
<td></td>
</tr>
<tr>
<td>Estimated Incentive Payment: $132,500</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $63,452</td>
<td>Year 3 Estimated Outcome Amount: $195,952</td>
</tr>
<tr>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong>&lt;br&gt;(10/1/2015 – 9/30/2016)</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**<br>(add outcome amounts over DYs 2-5): $736,404
**Unique ID:** 288523801.3.4  
**Performing Provider Name/TPI:** Tomball Regional Medical Center / 288523801  

**Title of Outcome Measure (Improvement Target):** OD-9 Right Care, Right Setting  
**Title of Outcome Measure (Improvement Target):** IT-9.2 ED appropriate utilization  
*(Standalone measure)*

- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)  
- Reduce Emergency Department visits for target conditions  
  - Congestive Heart Failure  
  - Diabetes  
  - End Stage Renal Disease  
  - Cardiovascular Disease /Hypertension  
  - Behavioral Health/Substance Abuse  
  - Chronic Obstructive Pulmonary Disease  
  - Asthma

This outcome measure is chosen because it reflects all of the above indicators. By increasing access to primary care, after-hours services, access to vaccinations and post hospital follow-up care patients will receive the right care in the right setting. This will result in conditions not escalating to the point that they require emergency and hospital services and thereby, improve the overall health of the patient population.

During 2012, Tomball Regional Medical Center has experienced a 10.4% growth in ED visits. Visits by uninsured patients have increased by 19.2%. A five percent reduction in visits from indigent and uninsured will reduce payments by payers and uncompensated care by $527,431.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>Process Milestone 3 [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Plan Documentation</td>
<td>Process Milestone 3 Estimated Incentive Payment: $31,726</td>
<td>Outcome Milestone 1 IT-9.2 ED appropriate Reduce pediatric Emergency Department visits Reduce Emergency Department visits for target conditions o Congestive Heart Failure o Diabetes o End Stage Renal Disease o Cardiovascular Disease /Hypertension o Behavioral Health/Substance Abuse o Chronic Obstructive Pulmonary Disease o Asthma Goal: 4% reductions from 2012 Data Source: ED registration data, claims data, HER Outcome Milestone 1 Estimated Incentive Payment (maximum amount): $421,944.</td>
<td>Process Milestone 1 IT-9.2 ED appropriate Reduce pediatric Emergency Department visits Reduce Emergency Department visits for target conditions o Congestive Heart Failure o Diabetes o End Stage Renal Disease o Cardiovascular Disease /Hypertension o Behavioral Health/Substance Abuse o Chronic Obstructive Pulmonary Disease o Asthma Goal: 5% reductions from 2012 Data Source: ED registration data, claims data, HER Process Milestone 1 Estimated Incentive Payment (maximum amount): $527,432.</td>
</tr>
<tr>
<td>Outcome Milestone 1 IT-9.2 ED appropriate Reduce pediatric Emergency Department visits Reduce Emergency Department visits for target conditions o Congestive Heart Failure o Diabetes o End Stage Renal Disease o Cardiovascular Disease /Hypertension o Behavioral Health/Substance Abuse o Chronic Obstructive Pulmonary Disease o Asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>288523801.1.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
</tr>
<tr>
<td>o Behavioral Health/Substance Abuse</td>
<td>Goal: 3% reductions from 2012</td>
<td>Data Source: ED registration data, claims data, HER</td>
<td>Outcome Milestone 1 Estimated Incentive Payment (<em>maximum amount</em>): $316,459.</td>
</tr>
<tr>
<td>o Chronic Obstructive Pulmonary Disease</td>
<td>Data Source: ED registration data, claims data, HER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Asthma</td>
<td>Goal: 2% reductions from 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: ED registration data, claims data, HER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome Milestone 1 Estimated Incentive Payment (<em>maximum amount</em>): $210,973.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $274,425</td>
<td>Year 3 Estimated Outcome Amount: $379,911</td>
<td>Year 4 Estimated Outcome Amount: $421,944</td>
<td>Year 5 Estimated Outcome Amount: $527,432</td>
</tr>
<tr>
<td>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (<em>add outcome amounts over DYs 2-5</em>): $1,603,712</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
University of Texas M.D. Anderson Cancer Center

Pass 1
Title of Outcome Measure (Improvement Target): IT-12.3 – Colorectal Cancer Screening (HEDIS 2012)

Unique RHP outcome identification number(s): 112672402.3.1

Outcome Measure Description:
IT-12.3 Colorectal Cancer Screening (HEDIS 2012)

Process Milestones:
- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:
- DY3: IT – 12.3 Number of adults aged 50 to 75 who receive one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years) – Improvement percent 1900% over baseline of 100. (The baseline is calculated for only one month of DY2. This accounts for the large percentage increase between DY2 baseline and DY3.)
- DY4: IT – 12.3 Number of adults aged 50 – 75 who receive one of the following screenings: a fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years) – Improvement percent 5% over DY3
- DY5: IT – 12.3 Number of adults aged 50 – 75 who receive one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years) – Improvement percent 5% over DY4

Rationale:
Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of CRC screening services. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

Improvement target percentages are based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up expansion period of a CRC screening program.

Outcome Measure Valuation:
We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]:</th>
<th>Process Milestone 3 [P-3]:</th>
<th>Outcome Improvement Target 2 [IT-12.3]: Colorectal Cancer Screening (HEDIS 2012)</th>
<th>Outcome Improvement Target 2-3 [IT-12.3]: Colorectal Cancer Screening (HEDIS 2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 [P-1.1]: Meetings with stakeholders and project staff to identify capacity</td>
<td>Develop and test data systems Metric 1 [P-3.1] Develop and test data system for tracking and reporting a. Data Source: Database b. Goals: Completed data tracking system c. Rational/Evidence: Process milestone P-3 was chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of CRC screening services. In order to report accurate data and establish baselines, P-3 must be approached in DY2-DY3.</td>
<td>a. Baseline: 2000 Goal: 2100 b. Numerator: Number of adults in clinic client population aged 50 to 75 who receive one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years c. Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded. d. Data Source: EHR, Claims e. Rational/Evidence: Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early</td>
<td>a. Baseline: 2100 Goal: 2205 b. Numerator: Number of adults in clinic client population aged 50 to 75 who receive one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years c. Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded. d. Data Source: EHR, Claims e. Rational/Evidence: Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early</td>
</tr>
<tr>
<td></td>
<td>Outcome Improvement Target 1 [IT-12.3]: Colorectal Cancer Screening (HEDIS 2012) a. Baseline: 100 Goal: 2000 b. Numerator: Number of adults in clinic client population aged 50 to 75 who receive one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years c. Denominator: Number of adults</td>
<td>a. Baseline: 2000 Goal: 2100 b. Numerator: Number of adults in clinic client population aged 50 to 75 who receive one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years c. Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded. d. Data Source: EHR, Claims e. Rational/Evidence: Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early</td>
<td>a. Baseline: 2100 Goal: 2205 b. Numerator: Number of adults in clinic client population aged 50 to 75 who receive one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years c. Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded. d. Data Source: EHR, Claims e. Rational/Evidence: Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early</td>
</tr>
</tbody>
</table>
| Process Milestone 3 Estimated Incentive Payment: $50,074.33 | **Outcome Improvement Target 2 [IT-12.3]: Colorectal Cancer Screening (HEDIS 2012)** a. Baseline: 2000 Goal: 2100 b. Numerator: Number of adults in clinic client population aged 50 to 75 who receive one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years c. Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded. d. Data Source: EHR, Claims e. Rational/Evidence: Screening for cancer implies testing for early stages of disease before symptoms occur. It
<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DY2. Aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded. d. Data Source: EHR, Claims e. Rational/Evidence: Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.</td>
<td>Preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.</td>
<td>Preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.</td>
<td>Outcome Improvement Target 2 Estimated Incentive Payment: $151,202.66</td>
</tr>
</tbody>
</table>

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**Unique CAT 3 ID:** 112672402.3.1

**Reference Number for RHP PP:** 3.IT-12.3

**Colorectal Cancer Screening (HEDIS 2012)**

**Starting Point/Baseline:** DY3 Baseline is 100 FIT tests distributed in DY2.

**Process Milestone 1 Estimated Incentive Payment:** $49,589.67

**Process Milestone 2 Estimated Incentive Payment:** $49,589.67

**Process Milestone 2 [P-3]: Develop and test data systems**

**Metric [P-2.1]** Develop and test data system for tracking and reporting

**a. Data Source:** Database

**b. Goals:** Completed data tracking system

**c. Rational/Evidence:** Process milestone P-3 was chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of CRC screening services. In order to report accurate data and establish baselines, milestone P-3 must be approached in DY2.

**Outcome Improvement Target 2 Estimated Incentive Payment:** $470,307.33
**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**Reference Number for RHP PP:** 3.IT-12.3

**Unique CAT 3 ID:** 112672402.3.1

**Unique Category 2 project identifier – 112672402.2.7**

**Colorectal Cancer Screening (HEDIS 2012)**

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Starting Point/Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
</tr>
</tbody>
</table>

DY3 Baseline is 100 FIT tests distributed in DY2.

that leads to a cost-effective and significant reduction in disease burden.

**Outcome Improvement Target 1**

**Estimated Incentive Payment (maximum amount):**

$50,074.33

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**

(add outcome amounts over DYs 2-5): $820,837.99

<table>
<thead>
<tr>
<th>Year 2 Estimated Outcome Amount:</th>
<th>$99,179.34</th>
<th>Year 3 Estimated Outcome Amount:</th>
<th>$100,148.66</th>
<th>Year 4 Estimated Outcome Amount:</th>
<th>$151,202.66</th>
<th>Year 5 Estimated Outcome Amount:</th>
<th>$470,307.33</th>
</tr>
</thead>
</table>

**Regional Healthcare Partnership Plan**

**Region 3**

2653
**Title of Outcome Measure (Improvement Target):** IT-12.6 – Other Outcome
Improvement Target: Flu vaccination status for adults age 50 – 75

**Unique RHP outcome identification number(s):** 112672402.3.2

**Outcome Measure Description:**
IT-12.6 Other Outcome Improvement Target: Flu vaccination status for adults age 50 – 75

**Process Milestones:**
- **DY2:**
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- **DY3:**
  - P-3 – Develop and test data systems

**Outcome Improvement Targets for each year:**
- **DY3:** IT – 12.6 Numerator: Number of adults aged 50 to who have received flu vaccination – Improvement percent 1900% over baseline of 100. (The baseline is calculated for only one month of DY2. This accounts for the large percentage increase between DY2 baseline and DY3.)
- **DY4:** IT – 12.6 Numerator: Number of adults aged 50 to who have received flu vaccination – Improvement percent 5% over DY 3
- **DY5:** IT – 12.6 Numerator: Number of adults aged 50 to who have received flu vaccination – Improvement percent 5% over DY4

**Rationale:**
Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of flu vaccination services. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

Improvement target percentages are based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a screening program.

**Outcome Measure Valuation:**
We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.
**Unique CAT 3 ID:**
112672402.3.2  

**Reference Number for RHP PP:**
3.IT-12.6  

**Other Outcome Improvement Target:**
Flu vaccination status for adults age 50 - 75  

**Performing Provider Name:**
The University of Texas MD Anderson Cancer Center  

**Related Category 1 or 2 Projects:**
Unique Category 2 project identifier – 112672402.2.7  

**Starting Point/Baseline:**
Baseline is 100 flu vaccinations given in DY2.

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong> [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 [P-1.1]: Meetings with stakeholders and project staff to identify capacity. a. Data Source: Minutes of meetings b. Goals: One meeting per clinic c. Rational/Evidence: Process milestone P-1 was chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of flu vaccination services. In order to report accurate data and establish baselines, P-1 must be approached in DY2.</td>
<td><strong>Process Milestone 2</strong> [P-2]: Develop and test data systems. Metric 1 [P-2.1]: Develop and test data system for tracking and reporting a. Data Source: Database b. Goals: Completed data tracking system c. Rational/Evidence: Process milestone P-1 was chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of flu vaccination services. In order to report accurate data and establish baselines, P-3 must be approached in DY2-DY3.</td>
<td><strong>Outcome Improvement Target 1</strong> IT-12.6 – Other Outcome Improvement Target: Flu vaccination status for adults age 50 – 75 a. Baseline: 2000 Goal: 2100 b. Numerator: Number of adults in clinic client population aged 50 to 75 who receive annual flu vaccination c. Denominator: Number of adults aged 50 to 75 in the patient or target population eligible to receive flu vaccination. d. Data Source: EHR, Claims e. Rationale/Evidence: Morbidity and mortality from influenza are “potentially preventable” by utilization of annual influenza immunization through appropriate outpatient healthcare. In 2010, the Advisory Committee on Immunization Practices (ACIP) first recommended annual influenza vaccination for all persons aged ≥6 months in the United States and annual influenza vaccination of all persons aged ≥6 months continues to be recommended.</td>
<td><strong>Outcome Improvement Target 2</strong> IT-12.6 – Other Outcome Improvement Target: Flu vaccination status for adults age 50 – 75 a. Baseline: 2100 Goal: 2205 b. Numerator: Number of adults in clinic client population aged 50 to 75 who receive annual flu vaccination c. Denominator: Number of adults aged 50 to 75 in the patient or target population eligible to receive flu vaccination. d. Data Source: EHR, Claims e. Rationale/Evidence: Morbidity and mortality from influenza are “potentially preventable” by utilization of annual influenza immunization through appropriate outpatient healthcare. In 2010, the Advisory Committee on Immunization Practices (ACIP) first recommended annual influenza vaccination for all persons aged ≥6 months in the United States and annual influenza vaccination of all persons aged ≥6 months continues to be recommended.</td>
</tr>
</tbody>
</table>

**Process Milestone 3 Estimated Incentive Payment:**
$50,074.33

**Outcome Improvement Target 1 Estimated Incentive Payment:**
$151,202.66

**Outcome Improvement Target 2 Estimated Incentive Payment:**
$470,307.33

Morbidity and mortality from influenza are “potentially preventable” by utilization of annual influenza immunization through appropriate outpatient healthcare. In 2010, the Advisory Committee on Immunization Practices (ACIP) first recommended annual influenza vaccination for all persons aged ≥6 months in the United States and annual influenza vaccination of all persons aged ≥6 months continues to be recommended.
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Unique Category 2 project identifier – 112672402.2.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline is 100 flu vaccinations given in DY2.</td>
</tr>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>report accurate data and establish baselines, P-1 must be approached in DY2.</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 1 Estimated Incentive Payment:</strong> $49,589.67</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2</strong> [P-3]: Develop and test data systems</td>
<td></td>
</tr>
<tr>
<td>Metric 1 [P-2.1] Develop and test data system for tracking and reporting</td>
<td></td>
</tr>
<tr>
<td>a. <strong>Data Source:</strong> Database</td>
<td></td>
</tr>
<tr>
<td>b. <strong>Goals:</strong> Completed data tracking system</td>
<td></td>
</tr>
<tr>
<td>c. <strong>Rationale/Evidence:</strong> Process milestone P-3 was chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of flu vaccination services. In order to report accurate data and establish baselines, P-3 must be approached in DY2.</td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2 Estimated Incentive Payment:</strong> $49,589.67</td>
<td></td>
</tr>
<tr>
<td>d. <strong>Data Source:</strong> EHR, Claims</td>
<td></td>
</tr>
<tr>
<td>e. <strong>Rationale/Evidence:</strong> Morbidity and mortality from influenza are “potentially preventable” by utilization of annual influenza immunization through appropriate outpatient healthcare. In 2010, the Advisory Committee on Immunization Practices (ACIP) first recommended annual influenza vaccination for all persons aged ≥6 months in the United States and annual influenza vaccination of all persons aged ≥6 months continues to be recommended.</td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target Estimated Incentive Payment:</strong> $50,074.33</td>
<td></td>
</tr>
<tr>
<td><strong>Unique CAT 3 ID:</strong></td>
<td><strong>Reference Number for RHP PP:</strong></td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>112672402.3.2</td>
<td>3.IT-12.6</td>
</tr>
</tbody>
</table>

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**TPI - 112672402**

**Related Category 1 or 2 Projects:**

**Unique Category 2 project identifier – 112672402.2.7**

**Starting Point/Baseline:**

- **Baseline is 100 flu vaccinations given in DY2.**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: $99,179.34</td>
<td>Year 3 Estimated Outcome Amount: $100,148.66</td>
<td>Year 4 Estimated Outcome Amount: $151,202.66</td>
<td>Year 5 Estimated Outcome Amount: $470,307.33</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $820,837.99
**Title of Outcome Measure (Improvement Target):** IT-12.6 – Other Outcome Improvement Target: Increase in compliance with annual flu vaccination and colorectal cancer screening.

**Unique RHP outcome identification number(s):** 112672402.3.3

**Outcome Measure Description:**
IT-12.6 – Other Outcome Improvement Target: Increase in compliance with annual flu vaccination and colorectal cancer screening.

**Process Milestones:**
- **DY2:**
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- **DY3:**
  - P-3 – Develop and test data systems

**Outcome Improvement Targets for each year:**
- **DY4:** IT – 12.6 Numerator: Number of adults aged 50 to 75 who returned for annual FIT colorectal screening and flu vaccination after receiving reminder – Improvement percent 15%
- **DY5:** IT – 12.6 Numerator: Number of adults aged 50 to 75 who returned for annual FIT colorectal screening and flu vaccination after receiving reminder – Improvement percent 15%

**Rationale:**
Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor patient compliance in returning for annual flu and colorectal cancer screening. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

Improvement target percentages are based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a CRC screening program.

**Outcome Measure Valuation:**
We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metric 1 [P-1.1]: Meetings with stakeholders and project staff to identify capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2  (10/1/2012 – 9/30/2013)</td>
</tr>
<tr>
<td>Process Milestone 2 [P-2]: Develop and test data systems</td>
</tr>
<tr>
<td>Metric 1 [P-2.1]: Develop and test data system for tracking and reporting</td>
</tr>
<tr>
<td>a. Data Source: Database</td>
</tr>
<tr>
<td>b. Goals: Completed data tracking system</td>
</tr>
<tr>
<td>Metric 2 [P-2.2]: Develop timeline and document implementation plan</td>
</tr>
<tr>
<td>a. Data Source: Timeline and project implementation documentation</td>
</tr>
<tr>
<td>b. Goal: Develop one project implementation plan</td>
</tr>
<tr>
<td>c. Rational/Evidence: Process milestone P-1 was chosen due to the lack of accurate reports and resources currently available to measure and monitor patient return for annual flu and CRC screening services. In order to report accurate data and establish baselines, P-1 must be approached in DY2.</td>
</tr>
<tr>
<td>Metric 2 [P-2.2]: Develop timeline and document implementation plan</td>
</tr>
<tr>
<td>a. Data Source: Timeline and project implementation documentation</td>
</tr>
<tr>
<td>b. Goal: Develop one project implementation plan</td>
</tr>
<tr>
<td>c. Rational/Evidence: Process milestone P-1 was chosen due to the lack of accurate reports and resources currently available to measure and monitor patient return for annual flu and CRC screening services. In order to report accurate data and establish baselines, P-1 must be approached in DY2.</td>
</tr>
<tr>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
</tr>
<tr>
<td>Metric 1 [P-3.1]: Develop and test data system for tracking and reporting</td>
</tr>
<tr>
<td>a. Data Source: Database</td>
</tr>
<tr>
<td>b. Goals: Completed data tracking system</td>
</tr>
<tr>
<td>c. Rational/Evidence: Process milestone P-3 was chosen due to the lack of accurate reports and resources currently available to measure and monitor patient return for annual flu and CRC screening services. In order to report accurate data and establish baselines, P-3 must be approached in DY2-DY3.</td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $50,074.33</td>
</tr>
<tr>
<td>Outcome Improvement Target 1 IT-12.6 – Other Outcome Improvement Target: Increase in compliance with annual flu vaccination and colorectal cancer screening.</td>
</tr>
<tr>
<td>a. Baseline: 100 Goal: 15</td>
</tr>
<tr>
<td>b. Denominator: Number of adults aged 50 to 75 who returned for annual FIT colorectal screening and flu vaccination after receiving reminder.</td>
</tr>
<tr>
<td>Outcome Improvement Target 2 IT-12.6 – Other Outcome Improvement Target: Increase in compliance with annual flu vaccination and colorectal cancer screening.</td>
</tr>
<tr>
<td>a. Baseline: 15 Goal: 315</td>
</tr>
<tr>
<td>b. Numerator: Number of adults aged 50 to 75 who returned for annual FIT colorectal screening and flu vaccination after receiving reminder.</td>
</tr>
<tr>
<td>c. Denominator: Number of adults aged 50 to 75 in the patient or target population who received FIT colorectal screening and flu vaccination in DY2.</td>
</tr>
<tr>
<td>d. Data Source: EHR, Claims</td>
</tr>
<tr>
<td>e. Rational/Evidence: Reminders inform health care providers it is time for a client’s cancer screening test an annual influenza immunization or that the client is overdue for screening. The reminders can be provided in different ways, such as in client charts or by e-mail. The Community Preventive Services Task Force recommends provider reminder systems based on strong evidence of their effectiveness in increasing adherence to annual screening recommendations.</td>
</tr>
<tr>
<td>Outcome Improvement Target 3 IT-12.6 – Other Outcome Improvement Target: Increase in compliance with annual flu vaccination and colorectal cancer screening.</td>
</tr>
<tr>
<td>a. Baseline: 315 Goal: 331</td>
</tr>
<tr>
<td>b. Numerator: Number of adults aged 50 to 75 who returned for annual FIT colorectal screening and flu vaccination after receiving reminder.</td>
</tr>
<tr>
<td>c. Denominator: Number of adults aged 50 to 75 in the patient or target population who received FIT colorectal screening and flu vaccination in DY2.</td>
</tr>
<tr>
<td>d. Data Source: EHR, Claims</td>
</tr>
<tr>
<td>e. Rational/Evidence: Reminders inform health care providers it is time for a client’s cancer screening test an annual influenza immunization or that the client is overdue for screening. The reminders can be provided in different ways, such as in client charts or by e-mail. The Community Preventive Services Task Force recommends provider reminder systems based on strong evidence of their effectiveness in increasing adherence to annual screening recommendations.</td>
</tr>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
</tr>
<tr>
<td>--------------------------------</td>
</tr>
<tr>
<td>baselines, milestone P-1 must be approached in DY2.</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $49,589.67</td>
</tr>
<tr>
<td>Process Milestone 2 [P-3]: Develop and test data systems</td>
</tr>
<tr>
<td>Metric 1 [P-2.1] Develop and test data system for tracking and reporting</td>
</tr>
<tr>
<td>a. Data Source: Database</td>
</tr>
<tr>
<td>b. Goals: Completed data tracking system</td>
</tr>
<tr>
<td>c. Rational/Evidence: Process milestone P-3 was chosen due to the lack of accurate reports and resources currently available to measure and monitor patient return for annual flu and CRC screening services. In order to report accurate data and establish baselines, P-3 must be approached in DY2.</td>
</tr>
<tr>
<td>d. Data Source: EHR, Claims</td>
</tr>
<tr>
<td>e. Rationale/Evidence: Reminders inform health care providers it is time for a client’s cancer screening test an annual influenza immunization or that the client is overdue for screening. The reminders can be provided in different ways, such as in client charts or by e-mail. The Community Preventive Services Task Force recommends provider reminder systems based on strong evidence of their effectiveness in increasing adherence to annual screening recommendations.</td>
</tr>
<tr>
<td>Outcome Improvement Target Estimated Incentive Payment: $50,074.33</td>
</tr>
</tbody>
</table>

## Performing Provider Name: The University of Texas MD Anderson Cancer Center

**Reference Number for RHP PP:** 3.IT-12.6

**Other Outcome Improvement Target:** Increase in compliance with annual flu vaccination and colorectal cancer screening

**Unique CAT 3 ID:** 112672402.3.3

**Unique Category 2 project identifier – 112672402.2.7**

**TPI - 112672402**

**Starting Point/Baseline:** Baseline is 15 return patients from DY2.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount: $99,179.34</td>
<td>Year 3 Estimated Outcome Amount: $100,148.66</td>
<td>Year 4 Estimated Outcome Amount: $151,202.66</td>
<td>Year 5 Estimated Outcome Amount: $470,307.33</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $820,837.99*
**Title of Outcome Measure (Improvement Target):** IT-11.6 – Other Outcome Improvement Target (Quit Attempts)

**Unique RHP outcome identification number(s):** 112672402.3.4

**Outcome Measure Description:**
IT-11.6 – Other Outcome Improvement Target (Quit Attempts)
- Numerator: Number of HIV+ smokers that make a quit attempt

**Process Milestones:**
- **DY2:**
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- **DY3:**
  - P-3 – Develop and test data systems

**Outcome Improvement Targets for each year:**
- **DY3:** IT – 11.6 Numerator: Number of HIV+ smokers that make a quit attempt – 75% (n=187) of enrollees (n=250) will make a successful quit attempt by 6-month follow-up
- **DY4:** IT – 11.6 Numerator: Number of HIV+ smokers that make a quit attempt – 75% (n=375) of enrollees (n=500) will make a successful quit attempt by 6-month follow-up
- **DY5:** IT – 11.6 Numerator: Number of HIV+ smokers that make a quit attempt – 75% (n=188) of the remaining enrollees (n=250) will make a successful quit attempt by 6-month follow-up

**Rationale:**
Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the quit attempts among HIV+ smokers. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

Improvement target percentages are based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a smoking cessation program for HIV+ smokers.

**Outcome Measure Valuation:**
We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.
<table>
<thead>
<tr>
<th>Year 2  (10/1/2012 – 9/30/2013)</th>
<th>Year 3  (10/1/2013 – 9/30/2014)</th>
<th>Year 4  (10/1/2014 – 9/30/2015)</th>
<th>Year 5  (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>Process Milestone 3 [P-3]: Develop and test data systems</td>
<td>Outcome Improvement Target [IT-11.6]: Other Outcome Improvement Target (Quit Attempts)</td>
<td>Outcome Improvement Target [IT-11.6]: Other Outcome Improvement Target (Quit Attempts)</td>
</tr>
<tr>
<td>Metric (P-1.1): Number of monthly meetings and production of planning guide</td>
<td>Metric (P-3.1): Production of project-related databases</td>
<td>Baseline/Goal: 187/375</td>
<td>Baseline/Goal: 562/188</td>
</tr>
<tr>
<td>Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries</td>
<td>Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries</td>
<td>Numerator: It is estimated that 187 program enrollees will have made a quit attempt by the beginning of DY4.</td>
<td>Numerator: It is estimated that 562 program enrollees will have made a quit attempt by the beginning of DY5.</td>
</tr>
<tr>
<td>Goals and Rationale: 1) Host monthly meetings with the goal of identifying potential barrier; 2) produce a detailed plan of action to guide planning, implementation, and evaluation efforts.</td>
<td>Goals and Rationale: Production of a systems to document smoking status screening, smoking status documentation, participant tracking, intervention delivery, and outcome variables (e.g., smoking abstinence, quit attempts)</td>
<td>Denominator: Number of HIV+ smokers that make a quit attempt by 6-month follow-up – 75% (n=375) of enrollees (n=500) will have made a successful quit attempt by the end of DY4.</td>
<td>Denominator: Number of HIV+ smokers that make a quit attempt by 6-month follow-up – 75% (n=188) of enrollees (n=250) will have made a successful quit attempt by the end of DY5.</td>
</tr>
<tr>
<td>Process Milestone 3 Estimated Incentive Payment: $50,074.33</td>
<td>Outcome Improvement Target Estimated Incentive Payment: $151,202.66</td>
<td>Rationale/Evidence: A successful quit attempt represents an important indicator of program efficacy. Of note, individuals that make an initial quit attempt are more likely to achieve abstinence.</td>
<td>Rationale/Evidence: A successful quit attempt represents an important indicator of program efficacy. Of note, individuals that make an initial quit attempt are more likely to achieve abstinence.</td>
</tr>
<tr>
<td>Process Milestone 2 [P-3]: Develop and test data systems</td>
<td></td>
<td>Data Source: Primary data collection to be recorded in medical records and program databases</td>
<td>Data Source: Primary data collection to be recorded in medical records and program databases</td>
</tr>
<tr>
<td>Metric (P-3.1): Production of project-related databases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goals and Rationale: Production of a systems to document smoking status screening, smoking status</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Outcome Improvement Target Estimated Incentive Payment: $470,307.33
<table>
<thead>
<tr>
<th><strong>Unique CAT 3 ID:</strong></th>
<th><strong>Reference Number for RHP PP:</strong></th>
<th><strong>Other Outcome Improvement Target (Quit Attempts)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>112672402.3.4</td>
<td>3.IT-11.6</td>
<td>TPI - 112672402</td>
</tr>
</tbody>
</table>

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**Related Category 1 or 2 Projects:**

**Unique Category 2 project identifier – 112672402.2.7**

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**documentation, participant tracking, intervention delivery, and outcome variables (e.g., smoking abstinence, quit attempts)**

**Process Milestone 2 Estimated Incentive Payment:** $49,589.67

**Rationale/Evidence:** A successful quit attempt represents an important indicator of program efficacy. Of note, individuals that make an initial quit attempt are more likely to achieve abstinence.

**Data Source:** Primary data collection to be recorded in medical records and program databases

**Outcome Improvement Target Estimated Incentive Payment:** $50,074.33

**Year 2 Estimated Outcome Amount:** $99,179.34

**Year 3 Estimated Outcome Amount:** $100,148.66

**Year 4 Estimated Outcome Amount:** $151,202.66

**Year 5 Estimated Outcome Amount:** $470,307.33

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $820,837.99
**Title of Outcome Measure (Improvement Target):** IT-11.6 – Other Outcome Improvement Target (Smoking Cessation - Staying Quit)

**Unique RHP outcome identification number(s):** 112672402.3.5

**Outcome Measure Description:**

IT-11.6 – Other Outcome Improvement Target (Smoking Cessation – Staying Quit)
- Numerator: Number of HIV+ smokers that will be abstinent at the time of follow-up

**Process Milestones:**
- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems

**Outcome Improvement Targets for each year:**
- DY3: IT – 11.6 Numerator: 25% of HIV+ smokers (n=62) will be abstinent at the time of 6-month follow-up
- DY4: IT – 11.6 Numerator: 25% of HIV+ smokers (n=125) will be abstinent at the time of 6-month follow-up
- DY5: IT – 11.6 Numerator: 25% of HIV+ smokers (n=63) will be abstinent at the time of 6-month follow-up

**Rationale:**

Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and smoking cessation resources currently available to measure and monitor the staying quit status of HIV+ smokers. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

Improvement target percentages are based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a smoking cessation program for HIV+ smokers.

**Outcome Measure Valuation:**

We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.
**Unique CAT 3 ID:** 112672402.3.5  
**Reference Number for RHP PP:** 3.IT-11.6  
**Other Outcome Improvement Target (Smoking Cessation – Staying Quit)**

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center  
**TPI - 112672402**

**Related Category 1 or 2 Projects:**  
**Unique Category 2 project identifier – 112672402.2.7**

**Year 2 (10/1/2012 – 9/30/2013)**

<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Process Milestone 3 [P-3]: Develop and test data systems</th>
<th>Outcome Improvement Target [IT-11.6]: Other Outcome Improvement Target (Smoking Cessation - Staying Quit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric (P-1.1): Number of monthly meetings and production of planning guide</td>
<td>Metric (P-3.1): Production of project-related databases</td>
<td>Baseline/Goal: 62/125</td>
</tr>
<tr>
<td>Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries</td>
<td>Data Source: EHR reports; Stakeholder meeting summaries</td>
<td>Numerator: By the beginning of DY4, we expect that 62 program enrollees will have achieved smoking abstinence at the 6-month follow-up.</td>
</tr>
<tr>
<td>Goals and Rationale: 1) Host monthly meetings with the goal of identifying potential barrier; 2) produce a detailed plan of action to guide planning, implementation, and evaluation efforts.</td>
<td>Goals and Rationale: Production of a systems to document smoking status screening, smoking status documentation, participant tracking, intervention delivery, and outcome variables (e.g., smoking abstinence or staying quit)</td>
<td>Denominator: We estimate that 25% (n=125) additional enrollees will be abstinent at 6-month follow-up by the end of DY4.</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $49,589.67</td>
<td>Process Milestone 3 Estimated Incentive Payment: $50,074.33</td>
<td>Rational/Evidence: A targeted 25% quit rate is based on previous work. Of note, without a formalized cessation program (as proposed) only 5% of smokers successfully quit.</td>
</tr>
</tbody>
</table>

**Year 3 (10/1/2013 – 9/30/2014)**

<table>
<thead>
<tr>
<th>Process Milestone 2 [P-3]: Develop and test data systems</th>
<th>Outcome Improvement Target [IT-11.6]: Other Outcome Improvement Target (Smoking Cessation - Staying Quit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric (P-3.1): Production of project-related databases</td>
<td>Baseline/Goal: 0/62</td>
</tr>
<tr>
<td>Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries</td>
<td>Numerator: Currently, smoking cessation services are not offered at Legacy</td>
</tr>
<tr>
<td>Goals and Rationale: Production of a systems to document smoking status screening, smoking status documentation, participant tracking, intervention delivery, and outcome variables (e.g., smoking abstinence or staying quit)</td>
<td>Denominator: We estimate that 25% (n=62) of enrollees will be abstinent at 6-month follow-up</td>
</tr>
<tr>
<td></td>
<td>Rational/Evidence: A targeted 25% quit rate is based on previous work. Of note, without a formalized cessation program (as proposed) only 5% of smokers successfully quit.</td>
</tr>
<tr>
<td></td>
<td>Data Source: Primary data collection, including expired CO and self-report data collected from enrollees and stored in program databases.</td>
</tr>
</tbody>
</table>

**Year 4 (10/1/2014 – 9/30/2015)**

| Outcome Improvement Target Estimated Incentive Payment: $151,202.66 |

**Year 5 (10/1/2015 – 9/30/2016)**

<table>
<thead>
<tr>
<th>Outcome Improvement Target [IT-11.6]: Other Outcome Improvement Target (Smoking Cessation – Staying Quit)</th>
<th>Outcome Improvement Target Estimated Incentive Payment: $470,307.33</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline/Goal: 187/63</td>
<td>Numerator: By the beginning of DY5, we expect that 187 program enrollees will have achieved smoking abstinence at the 6-month follow-up.</td>
</tr>
<tr>
<td>Numerator: By the beginning of DY5, we expect that 25% (n=63) of additional enrollees will be abstinent at 6-month follow-up by the end of DY5.</td>
<td>Denominator: We estimate that 25% (n=63) of additional enrollees will be abstinent at 6-month follow-up by the end of DY5.</td>
</tr>
<tr>
<td>Rational/Evidence: A targeted 25% quit rate is based on previous work. Of note, without a formalized cessation program (as proposed) only 5% of smokers successfully quit.</td>
<td>Rational/Evidence: A targeted 25% quit rate is based on previous work. Of note, without a formalized cessation program (as proposed) only 5% of smokers successfully quit.</td>
</tr>
<tr>
<td>Data Source: Primary data collection, including expired CO and self-report data collected from enrollees and stored in program databases.</td>
<td>Data Source: Primary data collection, including expired CO and self-report data collected from enrollees and stored in program databases.</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>Performing Provider Name: The University of Texas MD Anderson Cancer Center</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>TPI - 112672402</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unique Category 1 or 2 Project Identifier</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>tracking, intervention delivery, and outcome variables (e.g., smoking abstinence or staying quit)</td>
<td>cessation program (as proposed) only 5% of smokers successfully quit.  Data Source: Primary data collection, including expired CO and self-report data collected from enrollees and stored in program databases.</td>
<td>Outcome Improvement Target Estimated Incentive Payment: $50,074.33</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment</td>
<td>$49,589.67</td>
<td>$99,179.34 (add outcome amounts over DYs 2-5): $820,837.99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td>$99,179.34</td>
<td>$100,148.66</td>
<td>$151,202.66</td>
<td>$470,307.33</td>
</tr>
</tbody>
</table>

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD
Title of Outcome Measure (Improvement Target): IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity (Screening for Cigarette Smoking)

Unique RHP outcome identification number(s): 112672402.3.6

Outcome Measure Description:
IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity (Screening for Cigarette Smoking)
- Numerator: Number of HIV+ patients from Legacy Community Health Services screened for smoking

Process Milestones:
- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3 – DY5:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:
- DY3: IT-11.3 Number of HIV+ patients from Legacy Community Health Services screened for smoking – 90% (approximately 2000) of HIV+ patients from Legacy will be screened for current smoking
- DY4: IT-11.3 Number of HIV+ patients from Legacy Community Health Services screened for smoking – 90% (approximately 2000) of HIV+ patients from Legacy will be screened for current smoking
- DY5: IT-11.3 Number of HIV+ patients from Legacy Community Health Services screened for smoking – 90% (approximately 2000) of HIV+ patients from Legacy will be screened for current smoking

Rationale:
Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor screening for cigarette smoking services provided to HIV+ smokers. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

Improvement target percentages are based on the timeframe in which proactive smoking status procedures will be implemented in the Legacy clinic setting. The target percentage is based on previous research of similar screening and intervention delivery approaches. It is expected that this target will be achievable during the start-up period of the proposed smoking cessation program.

Outcome Measure Valuation:
We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.
Unique CAT 3 ID: 112672402.3.6
Reference Number for RHP PP: 3.IT-11.3

**Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity (Screening for Cigarette Smoking)**

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**Reference Number for RHP PP:** 3.IT-11.3

**Starting Point/Baseline:** The baseline for DY3 is currently 0 as there are no people currently enrolled in the program

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 2</strong></td>
<td><strong>Process Milestone 3</strong></td>
<td><strong>Outcome Improvement Target</strong></td>
</tr>
<tr>
<td>[P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td>[P-3]: Develop and test data systems</td>
<td>[P-3]: Develop and test data systems</td>
<td>[IT-11.3]: Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity (Screening for Cigarette Smoking)</td>
</tr>
<tr>
<td><strong>Metric (P-1.1):</strong> Number of monthly meetings and production of planning guide</td>
<td><strong>Metric (P-3.1):</strong> Production of project-related databases</td>
<td><strong>Outcome Improvement Target</strong></td>
<td><strong>Baseline/Goal:</strong> 2000 (from DY3)/2000</td>
</tr>
<tr>
<td>Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries</td>
<td>Goals and Rationale: Production of a system to document smoking status screening, smoking status documentation, participant tracking, intervention delivery, and outcome variables (e.g., smoking abstinence)</td>
<td><strong>Numerater:</strong> Currently, smoking status is not routinely documented at Legacy. By DY4, we will have screening procedures in place to systematically screen for smoking, and our goal is to maintain a rate of at least 90% (targeted in DY3) screened at each visit.</td>
<td><strong>Denominator:</strong> Number of HIV+ smokers screened for smoking – 90% (approximately 2000) of HIV+ patients screened</td>
</tr>
<tr>
<td><strong>Process Milestone 1 Estimated Incentive Payment:</strong> $49,589.67</td>
<td><strong>Process Milestone 3 Estimated Incentive Payment:</strong> $50,074.33</td>
<td><strong>Rationale/Evidence:</strong> The US Public Health Service recommends that smoking status assessment be conducted on every patient at every visit. Smoking cessation treatment should then be offered to all current smokers.</td>
<td><strong>Data Source:</strong> Primary data collection to be recorded in medical records and program databases</td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:**

Unique Category 1 or 2 project identifier – 112672402.2.7

**Regional Healthcare Partnership Plan**

Region 3

2669
<table>
<thead>
<tr>
<th>Unique CAT 3 ID:</th>
<th>Reference Number for RHP PP:</th>
<th>Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity (Screening for Cigarette Smoking)</th>
</tr>
</thead>
<tbody>
<tr>
<td>112672402.3.6</td>
<td>3.II-11.3</td>
<td>TPI - 112672402</td>
</tr>
</tbody>
</table>

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**Reference Number for RHP PP:** 3.IT-11.3

**Related Category 1 or 2 Projects:**

**Starting Point/Baseline:**
The baseline for DY3 is currently 0 as there are no people currently enrolled in the program

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>status screening, smoking status documentation, participant tracking, intervention delivery, and outcome variables (e.g., smoking abstinence)</td>
<td>smokers screened for smoking – 90% (approximately 2000) of HIV+ patients screened</td>
<td>and program databases</td>
<td>Outcome Improvement Target Estimated Incentive Payment: $470,307.33</td>
</tr>
<tr>
<td>Documented Rationale/Evidence: The US Public Health Service recommends that smoking status assessment be conducted on every patient at every visit. Smoking cessation treatment should then be offered to all current smokers.</td>
<td>Data Source: Primary data collection to be recorded in medical records and program databases</td>
<td>Outcome Improvement Target Estimated Incentive Payment: $151,202.66</td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 Estimated Incentive Payment: $49,589.67</td>
<td>Year 2 Estimated Outcome Amount: $99,179.34</td>
<td>Year 3 Estimated Outcome Amount: $100,148.66</td>
<td>Year 4 Estimated Outcome Amount: $151,202.66</td>
</tr>
<tr>
<td>Year 4 Estimated Outcome Amount: $151,202.66</td>
<td>Year 5 Estimated Outcome Amount: $470,307.33</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $820,837.99
Title of Outcome Measure (Improvement Target): IT-11.6 – Other Outcome Improvement Target: Reduce susceptibility to tobacco usage among adolescents aged 11 to 18 years (Reduction of Susceptibility to Tobacco Use)

Unique RHP outcome identification number(s): 112672402.3.7

Outcome Measure Description:

- IT-11.6: Other Outcome Improvement Target (Reduction of Susceptibility to Tobacco Use) – Reduce susceptibility to tobacco usage among adolescents 11 to 18 years of age.

Susceptibility to Smoking is measured by a 3-item scale. These items are as follows: "Are you seriously thinking about trying smoking sometime next year?", "Are you seriously thinking about trying smoking soon?", and "Will you smoke a cigarette if offered by a friend?". The response categories are (1) Definitely yes, (2) Probably yes, (3) Probably not, and (4) Definitely not. Failure to respond "Definitely not" to all three items signifies that the respondent is susceptible to smoking.

Process Milestones:

- DY2:
  - P-1 – Project planning and initiation – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems

- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY3: Numerator: Number of youth ages 11-18 assessed as susceptible to tobacco use at the beginning of DY3 (n=3,150) minus the number of youth ages 11-18 assessed as susceptible to tobacco use at the end of DY3 (n=3,080). Denominator: Number of youth assessed as susceptible to tobacco use at the beginning of DY3 (n=3,150). Improvement percent is 2% reduction in susceptibility (n=70) over baseline of 3,150.

- DY4: Numerator: Number of youth ages 11-18 assessed as susceptible to tobacco use at the beginning of DY4 (n=3,080) minus the number of youth ages 11-18 assessed as susceptible to tobacco use at the end of DY4 (n=3,065). Denominator: Number of youth assessed as susceptible to tobacco use at the beginning of DY4 (n=3,080). Improvement percent is approximately 0.5% reduction in susceptibility (n=15) over baseline of 3,080.

- DY5: Numerator: Number of youth ages 11-18 assessed as susceptible to tobacco use at the beginning of DY5 (n=3,065) minus the number of youth ages 11-18 assessed as susceptible to tobacco use at the end of DY5 (n=3,050). Denominator: Number of youth assessed as susceptible to tobacco use at the beginning of DY5 (n=3,065). Improvement percent is approximately 0.5% reduction in susceptibility (n=15) over baseline of 3,065.
Rationale:
The 2012 Report of the Surgeon General entitled, Preventing Tobacco Use Among Youth and Young Adults concluded that prevention efforts must focus on both adolescents and young adults because among adults who become daily smokers, nearly all first use of cigarettes occurs by 18 years of age (88%), with 99% of first use by 26 years of age. Furthermore, advertising and promotional activities by tobacco companies have been shown to cause the onset and continuation of smoking among adolescents and young adults. Finally, coordinated, multi-component interventions that combine mass media campaigns, price increases including those that result from tax increases, school-based policies and programs, and statewide or community-wide changes in smoke-free policies and norms are effective in reducing the initiation, prevalence, and intensity of smoking among youth and young adults.

Process milestones P-1 and P-3 were selected for the ASPIRE youth tobacco use prevention and cessation project based on the needs of the target population. To prepare for the project, we will also develop the program infrastructure and improve the program delivery systems (i.e. ASPIRE and provider training). Further, the metric of susceptibility was selected because it is a widely used measure in national and state surveys and is a strong predictor of smoking initiation in adolescents.(1)

Improvement target percentages are based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a smoking cessation and prevention program with respect to tobacco use reduction and susceptibility to tobacco use reduction among low income adolescents.

Outcome Measure Valuation:
We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY. Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.
Performing Provider Name: The University of Texas MD Anderson Cancer Center

Starting Point/Baseline: Baseline: number of Medicaid-eligible/indigent adolescents ages 11-18 susceptible to tobacco use in DY2 = 3050*

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

Process Milestone 1 [P-1]: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans for evidence-based ASPIRE program in RHP 3 counties.

Metric 1 [P-1.1]: Meeting(s) with stakeholders and project staff to identify current capacity and needed resources to reduce youth susceptibility to smoking.

Baseline/Goals: One meeting at each program site (schools/clinics)

Data Source: Meeting agendas, minutes and attendance rosters

Rationale/evidence: Process milestone P-1 was chosen due to the need to accurately identify current capacity and resources needed to deliver the ASPIRE program to adolescents susceptible to tobacco use.

Metric 2 [P-1.2]: Develop timeline and document implementation plan

Baseline/Goals: Develop one project implementation plan and timeline to

Process Milestone 2 [P-3]: Develop and test data systems

Metric 1 [P-3.1]: Develop and test data system for tracking and reporting

Baseline/goals: Implementation of data system and data systems test(s) to track number of Medicaid-eligible/indigent youth susceptible to smoking as defined by Susceptibility to Smoking scale.

Data source: Database and documentation of data systems test

Rationale/evidence: Process milestone P-3 was chosen due to need for current data on susceptibility to tobacco use of Medicaid-eligible/indigent youth. In order to report accurate data and establish baselines P-3 must be approached in DY2-DY3.

Process Milestone 3: Estimated Incentive Payment: $788,025.00

Outcome Improvement Target [IT-11.6]: Other Outcome Improvement Target (Reduction of Susceptibility to Tobacco Use) – Reduce susceptibility to tobacco use by 0.5% (n = 15) among 3,080 adolescents aged 11 to 18 years who are susceptible to tobacco use in RHP3 counties.

a. Baseline: 3,080 Goal: 3,065
b. Numerator: Number of youth ages 11-18 assessed as susceptible to tobacco use at the beginning of DY4 minus the number of youth ages 11-18 assessed as susceptible to tobacco use at the end of DY4.

c. Denominator: Number of youth assessed as susceptible to tobacco use at the beginning of DY4

d. Data Source: ASPIRE program database and adolescent surveys

e. Rationale/Evidence: Susceptibility to Smoking is a nationally recognized standard predictor of smoking initiation among youth. In research studies of predicting power, Susceptibility outperformed all the other known risk factors, such as smoking among best friends and parents, academic performance, depression, etc. For over 20 years, the Susceptibility to Smoking has been an...
Unique CAT 3 ID: 112672402.3.7
Reference Number for RHP PP: 3.IT-11.6
Other Outcome Improvement Target: Reduce susceptibility to tobacco use among adolescents aged 11 to 18 years (Reduction of Susceptibility)

Performing Provider Name: The University of Texas MD Anderson Cancer Center

TPI - 112672402

Related Category 1 or 2 Projects:

Unique Category 2 project identifier – 112672402.2.7

Starting Point/Baseline:

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>reduce susceptibility to smoking among Medicaid-eligible/indigent youth in RHP3.</td>
<td>Susceptibility to Tobacco Use) – Reduce susceptibility to tobacco use by 2% (n = 70) among 3,150 susceptible adolescents aged 11 to 18 years in RHP3 counties.</td>
<td>indispensable component of research, dissemination, and quality improvement activities pertinent to tobacco use prevention among adolescents; therefore, it will be employed in our project.</td>
<td>indispensable component of research, dissemination, and quality improvement activities pertinent to tobacco use prevention among adolescents; therefore, it will be employed in our project.</td>
</tr>
<tr>
<td>Data Source: Documented timeline and implementation plans</td>
<td>a. Baseline: 3,150 Goal: 3,080 b. Numerator: Number of youth ages 11-18 assessed as susceptible to tobacco use at the beginning of DY3 minus the number of youth ages 11-18 assessed as susceptible to tobacco use at the end of DY3 c. Denominator: Number of youth assessed as susceptible to tobacco use at the beginning of DY3</td>
<td>Outcome Improvement Target Estimated Incentive Payment: $1,576,050.00</td>
<td>Outcome Improvement Target Estimated Incentive Payment: $1,576,050.00</td>
</tr>
<tr>
<td>Rationale/evidence: Process milestone P-1 was chosen due to the need for development and documentation of an implementation plan and timeline to track progress towards and enhance the successful implementation of the ASPIRE program in RHP3 counties.</td>
<td>d. Data Source: ASPIRE program database and adolescent surveys e. Rationale/Evidence: Susceptibility to Smoking is a nationally recognized standard predictor of smoking initiation among youth. In research studies of predicting power, Susceptibility outperformed all the other known risk factors, such as smoking among best friends and parents, academic performance, depression, etc. For over 20 years, the Susceptibility to Smoking has been an indispensable component of research, dissemination, and quality improvement activities pertinent to tobacco use prevention among adolescents; therefore, it will be employed in our project.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 1: Estimated Incentive Payment: $787,500</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Milestone 2 [P-3]: Develop and test data systems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metric1[P-2.1]: Develop and test data system for tracking and reporting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline/goals: Implementation of data system and data systems test(s) to track number of Medicaid-eligible/indigent youth susceptible to smoking as defined by Susceptibility to Smoking scale.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data Source: Documented timeline and implementation plans

Rationale/evidence: Process milestone P-1 was chosen due to the need for development and documentation of an implementation plan and timeline to track progress towards and enhance the successful implementation of the ASPIRE program in RHP3 counties.

Process Milestone 1: Estimated Incentive Payment: $787,500

Process Milestone 2 [P-3]: Develop and test data systems

Metric1[P-2.1]: Develop and test data system for tracking and reporting

Baseline/goals: Implementation of data system and data systems test(s) to track number of Medicaid-eligible/indigent youth susceptible to smoking as defined by Susceptibility to Smoking scale.
**Unique CAT 3 ID:** 112672402.3.7  
**Reference Number for RHP PP:** 3.IT-11.6  
**Other Outcome Improvement Target:** Reduce susceptibility to tobacco use among adolescents aged 11 to 18 years (Reduction of Susceptibility)

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center  
**Related Category 1 or 2 Projects:** Unique Category 2 project identifier – 112672402.2.7

| **Data source:** Database and documentation of data systems test  
**Rationale/evidence:** Process milestone P-3 was chosen due to need for current data on susceptibility to tobacco use of Medicaid-eligible/indigent youth.  
**Process Milestone 2: Estimated Incentive Payment:** $787,500 |

| Year 2  
(10/1/2012 – 9/30/2013) | Year 3  
(10/1/2013 – 9/30/2014) | Year 4  
(10/1/2014 – 9/30/2015) | Year 5  
(10/1/2015 – 9/30/2016) |
|---|---|---|---|
| Baseline: number of Medicaid-eligible/indigent adolescents ages 11-18 susceptible to tobacco use in DY2 = 3050*  
| Tobacco use prevention among adolescents; therefore, it will be employed in our project.  
*According to the US Bureau of the US Census, the total estimated number of youth aged 11 to 18 years in RHP3 is approximately 1.3 million. We estimated that at least 25% of these adolescents are Medicaid eligible/indigent (about 305,500). Then we estimated that 5% of these low income adolescents (15,250) will enroll in this project (connecting to ASPIRE and/or introduced by providers during clinical encounters). According to results from the 2002 to 2008 National Surveys on Drug Use and Health, approximately 13% are current smokers (varies by age, gender, ethnicity and other factors). The estimated number of participants for this project is based on the aforementioned data source. Of the 15,250, 20% are estimated as being susceptible to tobacco use. This is 3050 adolescents.  
**Outcome Improvement Target Estimated Incentive Payment:** $788,025.00 | | | |
<table>
<thead>
<tr>
<th>Performing Provider Name</th>
<th>The University of Texas MD Anderson Cancer Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference Number for RHP PP</td>
<td>3.IT-11.6</td>
</tr>
<tr>
<td>Other Outcome Improvement Target: Reduce susceptibility to tobacco use among adolescents aged 11 to 18 years(Reduction of Susceptibility)</td>
<td></td>
</tr>
<tr>
<td>Unique CAT 3 ID</td>
<td>112672402.3.7</td>
</tr>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>Unique Category 2 project identifier – 112672402.2.7</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Baseline: number of Medicaid-eligible/indigent adolescents ages 11-18 susceptible to tobacco use in DY2 = 3050*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Baseline</th>
<th>Year 2 Estimated Outcome Amount</th>
<th>Year 3 Estimated Outcome Amount</th>
<th>Year 4 Estimated Outcome Amount</th>
<th>Year 5 Estimated Outcome Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(10/1/2012 – 9/30/2013)</td>
<td>$1,575,000.00</td>
<td>$1,576,050.00</td>
<td>$1,576,050.00</td>
<td>$1,576,050.00</td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
<td>$1,576,050.00</td>
<td>$1,576,050.00</td>
<td>$1,576,050.00</td>
<td>$1,576,050.00</td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
<td>$1,576,050.00</td>
<td>$1,576,050.00</td>
<td>$1,576,050.00</td>
<td>$1,576,050.00</td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
<td>$1,576,050.00</td>
<td>$1,576,050.00</td>
<td>$1,576,050.00</td>
<td>$1,576,050.00</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $6,303,150.00*
**Title of Outcome Measure (Improvement Target):** IT-11.6 – Other Outcome
Improvement Target: Increase quit attempts among adolescents aged 11 to 18 years (Quit Attempts)

**Unique RHP outcome identification number(s):** 112672402.3.8

**Outcome Measure Description:**
- **IT-11.6:** Other Outcome Improvement Target (Quit Attempts) – 30% of current smokers will make at least one quit attempt. In absolute numbers, we estimate 600 of 1,980 smokers will make at least one quit attempt.

  Quit Attempt represents trying to refrain from using tobacco for at least 24 hours or longer, but not resulting in quitting for an extended period of time (i.e., relapsing back to tobacco use).

**Process Milestones:**
- **DY2:**
  - P-1 – Project planning and initiation– engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans along with beginning the process of modernizing the ASPIRE program with its companion tools and resources
  - P-3 – Develop and test data systems and with completing the process of modernizing the ASPIRE program with its companion tools and resources
- **DY3:**
  - P-3 – Develop and test data systems

**Outcome Improvement Targets for each year:**
**IT-11.6:** Other Outcome Improvement Target (Quit Attempts) – Increase quit attempts for 24 hours among the estimated 1,980 smokers by 30% (n = 600).

The estimate of 1,980 smokers is based on current ASPIRE program data showing 13% of adolescents smoke with the denominator being the estimated 15,250 Medicaid/eligible youth who will enroll in the ASPIRE program from DY2 to DY5. Declining numbers are due to smaller populations in the RHP 3 counties that will be added in DY4 and DY5. Estimates of quit attempts for each year are as follows:
- **DY3:** 420 participants will try to quit
- **DY4:** 90 smokers will try to quit
- **DY5:** 90 smokers will try to quit

**Rationale:**
This project aims to reduce smoking initiation and facilitate smoking cessation among the vast majority of the aforementioned youth (i.e., ages 11 through 18 years). Importantly, it will address tobacco use among the most vulnerable low-income groups of youth in clinics and schools, involving health professionals in sustainable activities that will lead to a dramatic reduction of tobacco use among the target population.
According to the 2012 Report of the Surgeon General entitled, *Preventing Tobacco Use Among Youth and Young Adults*, coordinated, multi-component interventions that combine mass media campaigns, price increases including those that result from tax increases, school-based policies and programs, and statewide or community-wide changes in smoke-free policies and norms are effective in reducing the initiation, prevalence, and intensity of smoking among youth and young adults.

Process milestones P-1 and P-3 were selected for the ASPIRE youth tobacco use prevention and cessation project based on the needs of the target population. To prepare for the project, we will also develop the program infrastructure and improve the program delivery systems (i.e. ASPIRE and provider training).

Improvement target percentages are based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a smoking cessation and prevention program with respect to tobacco use reduction and susceptibility to tobacco use reduction among low income adolescents.

**Outcome Measure Valuation:**

We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY. Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.
<table>
<thead>
<tr>
<th><strong>Unique CAT 3 ID:</strong></th>
<th><strong>Reference Number for RHP PP:</strong></th>
<th><strong>Other Outcome Improvement Target:</strong> Increase quit attempts among adolescents aged 11 to 18 years (Quit Attempts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>112672402.3.8</td>
<td>3.IT-11.6</td>
<td>TPI - 112672402</td>
</tr>
</tbody>
</table>

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**Reference Category 2 project identifier – 112672402.2.7**

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of estimated smokers aged 11 to 18 years enrolled in ASPIRE program/1,980 smokers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
</tr>
</tbody>
</table>

**Process Milestone 1 [P-1]:** Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

**Metric 1 [P-1.1]:** Meeting(s) with stakeholders and project staff to identify current capacity and needed resources to increase quit attempts among adolescent smokers.

**Baseline/Goals:** One meeting at each program site (schools/clinics)

**Data Source:** Meeting agendas, minutes and attendance rosters

**Rationale/evidence:** Process milestone P-1 was chosen due to the need to accurately identify current capacity and resources needed to deliver the ASPIRE program, cessation services and treatment to adolescent smokers to increase quit attempts in this population.

**Process Milestone 2 [P-2]:** Develop and test data systems

**Metric 2 [P-2.1]:** Develop and test data system for tracking and reporting

**Baseline/goals:** Implementation of data system and data systems test(s) to track number of Medicaid-eligible/indigent youth smokers making a quit attempt.

**Data Source:** Database and documentation of data systems test

**Rationale/evidence:** Process milestone P-2 was chosen due to the need for current data on smoking behavior and quit attempts among Medicaid-eligible/indigent youth smokers in order to report accurate data and establish baselines P-3 must be approached in DY2-DY3.

**Process Milestone 3 [P-3]:** Develop and test data systems

**Metric 3 [P-3.1]:** Develop and test data system for tracking and reporting

**Baseline/goals:** Implementation of data system and data systems test(s) to track number of Medicaid-eligible/indigent youth smokers making a quit attempt.

**Data Source:** Database and documentation of data systems test

**Rationale/evidence:** Process milestone P-3 was chosen due to the need for current data on smoking behavior and quit attempts among Medicaid-eligible/indigent youth. In order to report accurate data and establish baselines P-3 must be approached in DY2-DY3.

**Process Milestone 3: Estimated Incentive Payment:** $788,025.00

**Outcome Improvement Target [IT-11.6]:** Other Outcome Improvement Target (Increase Quit Attempts) – Increase quit attempts for 24 hours among .04% of the estimated 1,980 (n = 90) adolescent smokers aged 11 to 18 years in RHP3 counties

**Baseline/Goal:** DY 3 baseline

**Improvement Target:** Enroll 5% of 3 counties’ adolescents in ASPIRE program

**Data Source:** ASPIRE data system and student surveys

**Rationale/evidence:** Quit Attempts is a standard outcomes measure in tobacco research and clinical activities. It has been convincingly demonstrated in hundreds of studies and summarized in the 2008 USPHS Clinical Practice Guideline on Treating Smoking and Nicotine Dependence that the number of quit attempts is highly predicting of the ultimate successful cessation of tobacco use. Therefore, it is imperative that this measure is included in our metrics for the current project.

**Outcome Improvement Target Estimated Incentive Payment:** $1,576,050.00

**Outcome Improvement Target Estimated Incentive Payment:** $1,576,050.00

**Outcome Improvement Target Estimated Incentive Payment:** $1,576,050.00

**Outcome Improvement Target Estimated Incentive Payment:** $1,576,050.00
<table>
<thead>
<tr>
<th><strong>Unique CAT 3 ID:</strong></th>
<th><strong>Reference Number for RHP PP:</strong></th>
<th><strong>Other Outcome Improvement Target:</strong> Increase quit attempts among adolescents aged 11 to 18 years (Quit Attempts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>112672402.3.8</td>
<td>3.IT-11.6</td>
<td>TPI - 112672402</td>
</tr>
</tbody>
</table>

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**Related Category 1 or 2 Projects:**

<table>
<thead>
<tr>
<th><strong>Starting Point/Baseline:</strong></th>
<th><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</th>
<th><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</th>
<th><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</th>
<th><strong>Year 5</strong>&lt;br&gt;(10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>

| **Rationale/evidence:** Process milestone P-1 was chosen due to the need for development and documentation of an implementation plan and timeline to track progress towards and enhance the successful implementation of the ASPIRE program and cessation treatment and program resources in RHP3 counties. |

**Process Milestone 1: Estimated Incentive Payment:** $787,500.00

**Process Milestone 2 [P-3]:** Develop and test data systems

**Metric1 [P-2.1]:** Develop and test data system for tracking and reporting quit attempts

**Baseline/goals:** Implementation of data system and data systems test(s)

**Data source:** Database and documentation of data systems test

**Rationale/evidence:** Process milestone P-3 was chosen due to need for current data on numbers smokers and quit attempts among Medicaid-eligible/indigent youth.

**Process Milestone 2: Estimated Incentive Payment:** $787,500.00

**Rationale/evidence:** Quit Attempts is a standard outcomes measure in tobacco research and clinical activities. It has been convincingly demonstrated in hundreds of studies and summarized in the 2008 USPHHS Clinical Practice Guideline on Treating Smoking and Nicotine Dependence that the number of quit attempts is highly predictive of the ultimate successful cessation of tobacco use. Therefore, it is imperative that this measure is included in our metrics for the current project.

**Outcome Improvement Target Estimated Incentive Payment:** $788,025.00
<table>
<thead>
<tr>
<th><strong>Unique CAT 3 ID:</strong></th>
<th><strong>Reference Number for RHP PP:</strong></th>
<th><strong>Other Outcome Improvement Target:</strong> Increase quit attempts among adolescents aged 11 to 18 years (Quit Attempts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>112672402.3.8</td>
<td>3.IT-11.6</td>
<td>TPI - 112672402</td>
</tr>
</tbody>
</table>

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**Related Category 1 or 2 Projects:**

**Unique Category 2 project identifier – 112672402.2.7**

**Starting Point/Baseline:**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Starting Point/Baseline:**

- Number of estimated smokers aged 11 to 18 years enrolled in ASPIRE program/1,980 smokers

**Year 2 Estimated Outcome Amount:** $1,575,000.00

**Year 3 Estimated Outcome Amount:** $1,576,050.00

**Year 4 Estimated Outcome Amount:** $1,576,050.00

**Year 5 Estimated Outcome Amount:** $1,576,050.00

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** (add outcome amounts over DYs 2-5): $6,303,150.00
**Title of Outcome Measure (Improvement Target):** IT-11.6 – Other Outcome
Improvement Target: Increase cessation among adolescents aged 11 to 18 years (Smoking Cessation/Staying Quit)

**Unique RHP outcome identification number(s):** 112672402.3.9

**Outcome Measure Description:**

- **IT-11.6:** Other Outcome Improvement Target (Smoking Cessation/Staying Quit) – 10% (n=200) of enrollees who smoke will be abstinent at the time of follow-up.

  Staying Quit represents a successful quit attempt that results in continuous abstinence for at least 3 months (some researchers use longer time periods, for example at least 6 months). It is a standard outcome used in multiple tobacco control studies and clinical activities. The metric signifies the ultimate long-term success of the smoking cessation interventions among adolescents and adults. We will use this utmost important measure of abstinence to demonstrate the effect of the proposed tobacco cessation activities within the framework of ASPIRE as well as the counseling sessions provided by trained health professionals enrolled in the proposed project.

**Process Milestones:**

- **DY2:**
  - P-1 – Project planning and initiation– engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans along with beginning the process of modernizing the ASPIRE program with its companion tools and resources
  - P-3 – Develop and test data systems and with completing the process of modernizing the ASPIRE program with its companion tools and resources

- **DY3:**
  - P-3 – Develop and test data systems

**Outcome Improvement Targets for each year:**

- **IT-11.6:** Other Outcome Improvement Target (Smoking Cessation/Staying Quit) – Increase sustained cessation by 10% (n = 200) among the estimated 1,980 smokers in RHP3. Estimated numbers of those staying quit for each year are as follows:

  - DY3: 100 smokers will be sustained quitters
  - DY4: 50 smokers will be sustained quitters
  - DY5: 50 smokers will be sustained quitters

**Rationale:**

This project aims to reduce smoking initiation and facilitate smoking cessation among Medicaid-eligible/indigent youth ages 11 through 18 years old. Importantly, it will address tobacco use among the most vulnerable low-income groups of youth in clinics and schools, involving health...
professionals in sustainable activities that will lead to a dramatic reduction of tobacco use among the target population.

According to the 2012 Report of the Surgeon General entitled, *Preventing Tobacco Use Among Youth and Young Adults*, coordinated, multi-component interventions that combine mass media campaigns, price increases including those that result from tax increases, school-based policies and programs, and statewide or community-wide changes in smoke-free policies and norms are effective in reducing the initiation, prevalence, and intensity of smoking among youth and young adults.

Process milestones P-1 and P-3 were selected for the ASPIRE youth tobacco use prevention and cessation project based on the needs of the target population. To prepare for the project, we will also develop the program infrastructure and improve the program delivery systems (i.e. ASPIRE and provider training).

Improvement target percentages will be based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a smoking cessation and prevention program with respect to tobacco use reduction and susceptibility to tobacco use reduction among low income adolescents.

**Outcome Measure Valuation:**

We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY. Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Process Milestone 1 [P-1]:** Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
Metric [P-1.1]: Meeting(s) with stakeholders and project staff to identify current capacity and needed resources to increase cessation (staying quit) among adolescent smokers.  
Baseline/Goals: One meeting at each program site (schools/clinics)  
Data Source: Meeting agendas, minutes and attendance rosters  
Rationale/evidence: Process milestone P-1 was chosen due to the need to accurately identify current capacity and resources needed to deliver the ASPIRE program, cessation services and treatment to adolescent smokers to increase cessation (staying quit) in this population.

**Process Milestone 2 [P-1.2]:** Develop timeline and document implementation plan  
Baseline/Goals: Develop one project implementation plan and timeline to increase sustained cessation (staying quit) among Medicaid-eligible/indigent adolescent smokers.

**Process Milestone 3 [P-3]:** Develop and test data systems  
Metric [P-3.1]: Develop and test data system for tracking and reporting  
Baseline/goals: Implementation of data system and data systems test(s) to track number of Medicaid-eligible/indigent youth smokers staying quit.  
Data source: Database and documentation of data systems test  
Rationale/evidence: Process milestone P-3 was chosen due to the need for current data on smoking behavior, quit attempts and sustained cessation (staying quit) among Medicaid-eligible/indigent youth. In order to report accurate data and establish baselines P-3 must be approached in DY2-DY3.

**Process Milestone 3: Estimated Incentive Payment:** $788,025.00  
**Outcome Improvement Target [IT-11.6]:** Other Outcome Improvement Target (Increase cessation) – Increase sustained cessation of tobacco use among .02% of the estimated 1,980 adolescent smokers in RHP3 (n = 50).  
Baseline/Goal: DY 3 baseline  
**Improvement Target:** Enroll 5% of 3 counties’ adolescents in ASPIRE program  
Data Source: ASPIRE data system and student surveys  
Rationale/evidence: Staying quit is a standard outcome used in multiple tobacco control studies and clinical activities. The metric signifies the ultimate long-term success of the smoking cessation interventions among adolescents and adults. We will use this utmost important measure of abstinence to demonstrate the effect of the proposed tobacco cessation activities within the framework of ASPIRE as well as the counseling sessions provided by trained health professionals enrolled in the proposed project.

**Outcome Improvement Target Estimated Incentive Payment:** $1,576,050.00
<table>
<thead>
<tr>
<th>Related Category 1 or 2 Projects:</th>
<th>Related Category 1 or 2 Projects:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique Category 2 project identifier – 112672402.2.7</td>
<td>Unique Category 2 project identifier – 112672402.2.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Starting Point/Baseline:</th>
<th>Starting Point/Baseline:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid-eligible/indigent youth smokers enrolled in ASPIRE who are abstinent from smoking at follow-up</td>
<td>Medicaid-eligible/indigent youth smokers enrolled in ASPIRE who are abstinent from smoking at follow-up</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source: Documented timeline and implementation plans</td>
<td>Baseline/Goal: 4,100 students previously enrolled in Houston area</td>
<td>Improvement Target: Enroll 5% of 3 counties’ adolescents in ASPIRE program</td>
<td>Data Source: Documented timeline and implementation plans</td>
</tr>
<tr>
<td>Rationale/evidence: Process milestone P-1 was chosen due to the need for development and documentation of an implementation plan and timeline to track progress towards and enhance the successful implementation of the ASPIRE program and cessation treatment and program resources in RHP3 counties.</td>
<td>Data Source: ASPIRE data system and student surveys</td>
<td>Rationale/evidence: Staying quit is a standard outcome used in multiple tobacco control studies and clinical activities. The metric signifies the ultimate long-term success of the smoking cessation interventions among adolescents and adults. We will use this utmost important measure of abstinence to demonstrate the effect of the proposed tobacco cessation activities within the framework of ASPIRE as well as the counseling sessions provided by trained health professionals enrolled in the proposed project.</td>
<td>Rationale/evidence: Process milestone P-3 was chosen due to need for current data on numbers smokers, quit attempts and sustained cessation (staying quit) among Medicaid-eligible/indigent youth.</td>
</tr>
</tbody>
</table>

**Process Milestone 1: Estimated Incentive Payment:** $787,500.00

**Process Milestone 2 [P-3]: Develop and test data systems**

**Metric1[P-2.1]: Develop and test data system for tracking and reporting sustained cessation (staying quit)**

**Baseline/goals:** Implementation of data system and data systems test(s)

**Data source:** Database and documentation of data systems test

**Rationale/evidence:** Process milestone P-3 was chosen due to need for current data on numbers smokers, quit attempts and sustained cessation (staying quit) among Medicaid-eligible/indigent youth.

**Process Milestone 2: Estimated Incentive Payment:** $787,500.00

**Outcome Improvement Target Estimated Incentive Payment:** $788,025.00
<table>
<thead>
<tr>
<th><strong>Unique CAT 3 ID:</strong></th>
<th><strong>Reference Number for RHP PP:</strong></th>
<th><strong>Other Outcome Improvement Target:</strong> Increase cessation among adolescents aged 11 to 18 years (Staying Quit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>112672402.3.9</td>
<td>3.IT-11.6</td>
<td>--------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center  
**TPI - 112672402**

**Related Category 1 or 2 Projects:** Unique Category 2 project identifier – 112672402.2.7

**Starting Point/Baseline:** Medicaid-eligible/indigent youth smokers enrolled in ASPIRE who are abstinent from smoking at follow-up

<table>
<thead>
<tr>
<th><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</th>
<th><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</th>
<th><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</th>
<th><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Estimated Outcome Amount:</td>
<td>Year 3 Estimated Outcome Amount:</td>
<td>Year 4 Estimated Outcome Amount:</td>
<td>Year 5 Estimated Outcome Amount:</td>
</tr>
<tr>
<td>$1,575,000.00</td>
<td>$1,576,050.00</td>
<td>$1,576,050.00</td>
<td>$1,576,050.00</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):** $6,303,150.00
**Title of Outcome Measure (Improvement Target):** IT-12.6 Other Outcome Improvement Target: Women in need of diagnostic test(s)

**Unique RHP outcome identification number(s):** 112672402.3.10

**Outcome Measure Description:**
IT-12.6 Other Outcome Improvement Target: Women in need of diagnostic test(s)

**Process Milestones:**
- **DY2:**
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- **DY3:**
  - P-3 – Develop and test data systems

**Outcome Improvement Targets for each year:**
- **DY3:** IT-12.6 Numerator: Number of women who completed follow up/diagnostic test(s) with program partner(s) – Improvement percent 50% of those referred for diagnostic test(s) with program partners
- **DY4:** IT-12.6 Numerator: Number of women who completed follow up/diagnostic test(s) with program partner(s) – Improvement percent 50% of those referred for diagnostic test(s) with program partners
- **DY5:** IT-12.6 Numerator: Number of women who completed follow up/diagnostic test(s) with program partner(s) – Improvement percent 50% of those referred for diagnostic test(s) with program partners

**Rationale:**
Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the number of women in the program that need diagnostic services. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

Improvement target percentages are based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the expansion period of a breast cancer screening program.

**Outcome Measure Valuation:**
We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.
**Unique CAT 3 ID:** 112672402.3.10  
**Reference Number for RHP PP:** 3.IT-12.6  
**Other Outcome Improvement Target:** Women in need of diagnostic test(s)

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center  
**TPI - 112672402**

**Related Category 1 or 2 Projects:** Unique Category 2 project identifier – 112672402.2.7

| Starting Point/Baseline: | Year 2  
| | (10/1/2012 – 9/30/2013) |
| Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
Metric 1 [P-1.1]: Meeting with participating clinic staff and program staff  
a. **Data Source:** Stakeholder meeting summaries; Staff meeting summaries  
b. **Goals:** One meeting per clinic  
c. **Rational/Evidence:** Process milestone P-1 was chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of diagnostic services. In order to report accurate data and establish baselines, P-1 must be approached in DY2.  
| Process Milestone 3 [P-3]: Develop and test data systems  
Metric 1 [P-3.1]: Develop and test data system for tracking and reporting  
a. **Data Source:** Develop and test data system for tracking and reporting  
b. **Goals:** Completed data tracking system  
c. **Rational/Evidence:** Process milestone P-3 was chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of diagnostic services. In order to report accurate data and establish baselines, P-3 must be approached in DY3.  
| Process Milestone 3 Estimated Incentive Payment: | $50,074.33 |
| | Year 3  
| | (10/1/2013 – 9/30/2014) |
| Outcome Improvement Target IT-12.6 Other Outcome Improvement Target: Women in need of diagnostic test(s)  
a. **Baseline:** 120 women referred for diagnostic test(s) with program partner(s)/Goal: 60 women who follow up with recommended diagnostic test(s) with program partner(s)  
b. **Numerator:** Number of women who completed follow up/diagnostic test(s) with program partner(s) (n=60)  
c. **Denominator:** Number of women referred for diagnostic test(s) with program partners (n=120)  
d. **Data:** EHR reports/Patient records  
e. **Rational/Evidence:** Based on our current Project VALET program, approximately 10% of women screened are referred for diagnostic test(s); hence, the estimated 120 women who will be referred for diagnostic test(s). The use of navigation services and promoting system changes is imperative in reaching the aforementioned outcome measures. For example, to increase the number of women who return for an annual follow up/diagnostic test(s) with program partner(s).  
| | Year 4  
| | (10/1/2014 – 9/30/2015) |
| Outcome Improvement Target IT-12.6 Other Outcome Improvement Target: Women in need of diagnostic test(s)  
a. **Baseline:** 150 women referred for diagnostic test(s) with program partner(s)/Goal: 75 women who follow up with recommended diagnostic test(s) with program partner(s)  
b. **Numerator:** Number of women who completed follow up/diagnostic test(s) with program partner(s) (n=75)  
c. **Denominator:** Number of women referred for diagnostic test(s) with program partners (n=150)  
d. **Data:** EHR reports/Patient records  
e. **Rational/Evidence:** Based on our current Project VALET program, approximately 10% of women screened are referred for diagnostic test(s); hence, the estimated 120 women who will be referred for diagnostic test(s). The use of navigation services and promoting system changes is imperative in reaching the aforementioned outcome measures. For example, to increase the number of women who return for an annual follow up/diagnostic test(s) with program partner(s).  
| | Year 5  
| | (10/1/2015 – 9/30/2016) |

**Outcome Improvement Target IT-12.6 Other Outcome Improvement Target: Women in need of diagnostic test(s)**

**Baseline:** 80 women referred for diagnostic test(s) with program partner(s)/Goal: 40 women who follow up with recommended diagnostic test(s) with program partner(s)
<table>
<thead>
<tr>
<th><strong>Unique CAT 3 ID:</strong></th>
<th>112672402.3.10</th>
<th><strong>Reference Number for RHP PP:</strong></th>
<th>3.IT-12.6</th>
<th><strong>Other Outcome Improvement Target:</strong> Women in need of diagnostic test(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performing Provider Name:</strong></td>
<td>The University of Texas MD Anderson Cancer Center</td>
<td></td>
<td></td>
<td><strong>TPI - 112672402</strong></td>
</tr>
<tr>
<td><strong>Related Category 1 or 2 Projects:</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>Unique Category 2 project identifier – 112672402.2.7</strong></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>Baseline in DY2 = 0</strong></td>
</tr>
<tr>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
<td><strong>Year 4</strong></td>
<td><strong>Year 5</strong></td>
<td></td>
</tr>
<tr>
<td><strong>of diagnostic services. In order to report accurate data and establish baselines, P-1 must be approached in DY2.</strong></td>
<td><strong>b. Numerator: Number of women who completed follow up/diagnostic test(s) with program partner(s) (n=40)</strong></td>
<td><strong>screening mammogram, navigators will incorporate evidence-based reminder systems such as mailing postcards one month before their next annual screening mammogram. The MD Anderson Mobile Mammography Appointment line will also call women 24-hours prior to their scheduled mammogram. Both have been deemed as providing “strong evidence of their effectiveness in increasing breast cancer screening by mammography,” by The Guide to Community Preventive Services.</strong></td>
<td><strong>screening mammogram, navigators will incorporate evidence-based reminder systems such as mailing postcards one month before their next annual screening mammogram. The MD Anderson Mobile Mammography Appointment line will also call women 24-hours prior to their scheduled mammogram. Both have been deemed as providing “strong evidence of their effectiveness in increasing breast cancer screening by mammography,” by The Guide to Community Preventive Services.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2 [P-3]: Develop and test data systems</strong></td>
<td><strong>c. Denominator: Number of women referred for diagnostic test(s) with program partners (n=80)</strong></td>
<td><strong>Outcome Improvement Target Estimated Incentive Payment:</strong></td>
<td><strong>Outcome Improvement Target Estimated Incentive Payment:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Metric 1 [P-3.1]: Develop and test data system for tracking and reporting</strong></td>
<td><strong>d. Data: EHR reports/Patient records</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. <strong>Data Source:</strong> Develop and test data system for tracking and reporting</td>
<td><strong>e. Rational/Evidence:</strong> Based on our current Project VALET program, approximately 10% of women screened are referred for diagnostic test(s); hence, the estimated 80 women who will be referred for diagnostic test(s). The use of navigation services and promoting system changes is imperative in reaching the aforementioned outcome measures. For example, to increase the number of women who return for an annual screening mammogram, navigators will incorporate evidence-based reminder systems such as mailing postcards one month. The use of navigation services and promoting system changes is imperative in reaching the aforementioned outcome measures. For example, to increase the number of women who return for an annual screening mammogram, navigators will incorporate evidence-based reminder systems such as mailing postcards one month.</td>
<td><strong>$151,202.66</strong></td>
<td><strong>$470,307.33</strong></td>
<td></td>
</tr>
<tr>
<td>b. <strong>Goals:</strong> Completed data tracking system</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. <strong>Rational/Evidence:</strong> Process milestone P-3 was chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of diagnostic services. In order to report accurate data and establish baselines, P-3 must be approached in DY2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Milestone 2 Estimated Incentive Payment:</strong></td>
<td><strong>$49,589.66</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 2 Baseline</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>before their next annual screening mammogram. The MD Anderson Mobile Mammography Appointment line will also call women 24-hours prior to their scheduled mammogram. Both have been deemed as providing “strong evidence of their effectiveness in increasing breast cancer screening by mammography,” by The Guide to Community Preventive Services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome Improvement Target</strong>&lt;br&gt;&lt;br&gt;<strong>Estimated Incentive Payment:</strong>&lt;br&gt;$50,074.33</td>
<td>Year 3 Estimated Outcome Amount: $100,148.66</td>
<td>Year 4 Estimated Outcome Amount: $151,202.66</td>
<td>Year 5 Estimated Outcome Amount: $470,307.33</td>
<td></td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $99,179.33</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD**<br>(add outcome amounts over DYs 2-5): $802,837.98
**Title of Outcome Measure (Improvement Target):** IT-12.6 Other Outcome Improvement Target: Women returning for an annual mammogram per recommended screening guidelines

**Unique RHP outcome identification number(s):** 112672402.3.11

**Outcome Measure Description:**
IT-12.6 Other Outcome Improvement Target: Women returning for an annual mammogram per recommended screening guidelines

**Process Milestones:**
- **DY2:**
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- **DY3:**
  - P-3 – Develop and test data systems

**Outcome Improvement Targets for each year:**
- **DY4:** IT-12.6 Numerator: Number of women ages 40 to 69, who return for their annual screening mammogram through Project VALET, thus demonstrating compliance with ACS screening guidelines – Improvement percent 20% of women screened
- **DY5:** IT-12.6 Numerator: Number of women ages 40 to 69, who return for their annual screening mammogram through Project VALET, thus demonstrating compliance with ACS screening guidelines – Improvement percent 25% of women screened

**Rationale:**
Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the women participating in the project that return for an annual mammogram per screening guidelines. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

Improvement target percentages are based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the expansion period of a breast cancer screening program.

**Outcome Measure Valuation:**
We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.
### Unique CAT 3 ID:
112672402.3.11

### Reference Number for RHP PP:
3.IT-12.6

### Other Outcome Improvement Target: Women returning for an annual mammogram per recommended screening guidelines

### Performing Provider Name:
The University of Texas MD Anderson Cancer Center

### Related Category 1 or 2 Projects:
Unique Category 2 project identifier – 112672402.2.7

### Starting Point/Baseline:
Baseline in DY2 is 0; This tracking is not part of the existing Project VALET

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

### Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

**Metric 1 [P-1.1]: Meeting with participating clinic staff and program staff**
- **Data Source:** Stakeholder meeting summaries; Staff meeting summaries
- **Goals:** One meeting per clinic
- **Rational/Evidence:** Process milestone P-1 was chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of annual breast cancer screening services. In order to report accurate data and establish baselines, P-1 must be approached in DY2.

**Metric 2 [P-1.2]: Develop timeline and document implementation plan**
- **Data Source:** Timeline and project implementation documents
- **Goals:** Develop one implementation plan
- **Rational/Evidence:** Process milestone P-1 was chosen due to the lack of accurate reports and resources currently available to

### Process Milestone 3 [P-3]: Develop and test data systems

**Metric 1 [P-3.1]: Develop and test data system for tracking and reporting**
- **Data Source:** Develop and test data system for tracking and reporting
- **Goals:** Completed data tracking system
- **Rational/Evidence:** Process milestone P-3 was chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of annual breast cancer screening services. In order to report accurate data and establish baselines, P-3 must be approached in DY3.

### Process Milestone 3 Estimated Incentive Payment:
$100,148.66

### Outcome Improvement Target IT-12.6 Other Outcome Improvement Target: Women returning for an annual mammogram per recommended screening guidelines

- **Baseline:** 0/Goal: 160
- **Numerator:** Number of women ages 40 to 69, who return for their annual screening mammogram through Project VALET, thus demonstrating compliance with ACS screening guidelines
- **Denominator:** Number of women ages 40 to 69, screened through Project VALET from the previous year
- **Data:** EHR reports/Patient records
- **Rational/Evidence:** Program staff will track the number of women who return for their annual mammogram; the use of navigation services and promoting system changes is imperative in reaching the aforementioned outcome measures. For example, to increase the number of women who return for an annual screening mammogram, navigators will incorporate evidence-based reminder systems such as mailing postcards one

### Process Milestone 3 Estimated Incentive Payment:
$100,148.66

### Outcome Improvement Target IT-12.6 Other Outcome Improvement Target: Women returning for an annual mammogram per recommended screening guidelines

- **Baseline:** 160/Goal: 300
- **Numerator:** Number of women ages 40 to 69, who return for their annual screening mammogram through Project VALET, thus demonstrating compliance with ACS screening guidelines
- **Denominator:** Number of women ages 40 to 69, screened through Project VALET from the previous year
- **Data:** EHR reports/Patient records
- **Rational/Evidence:** Program staff will track the number of women who return for their annual mammogram; the use of navigation services and promoting system changes is imperative in reaching the aforementioned outcome measures. For example, to increase the number of women who return for an annual screening mammogram, navigators will incorporate evidence-based reminder systems such as mailing postcards one

### Process Milestone 3 Estimated Incentive Payment:
$100,148.66

### Outcome Improvement Target IT-12.6 Other Outcome Improvement Target: Women returning for an annual mammogram per recommended screening guidelines

- **Baseline:** 160/Goal: 300
- **Numerator:** Number of women ages 40 to 69, who return for their annual screening mammogram through Project VALET, thus demonstrating compliance with ACS screening guidelines
- **Denominator:** Number of women ages 40 to 69, screened through Project VALET from the previous year
- **Data:** EHR reports/Patient records
- **Rational/Evidence:** Program staff will track the number of women who return for their annual mammogram; the use of navigation services and promoting system changes is imperative in reaching the aforementioned outcome measures. For example, to increase the number of women who return for an annual screening mammogram, navigators will incorporate evidence-based reminder systems such as mailing postcards one

### Process Milestone 3 Estimated Incentive Payment:
$100,148.66

### Outcome Improvement Target IT-12.6 Other Outcome Improvement Target: Women returning for an annual mammogram per recommended screening guidelines

- **Baseline:** 160/Goal: 300
- **Numerator:** Number of women ages 40 to 69, who return for their annual screening mammogram through Project VALET, thus demonstrating compliance with ACS screening guidelines
- **Denominator:** Number of women ages 40 to 69, screened through Project VALET from the previous year
- **Data:** EHR reports/Patient records
- **Rational/Evidence:** Program staff will track the number of women who return for their annual mammogram; the use of navigation services and promoting system changes is imperative in reaching the aforementioned outcome measures. For example, to increase the number of women who return for an annual screening mammogram, navigators will incorporate evidence-based reminder systems such as mailing postcards one

### Process Milestone 3 Estimated Incentive Payment:
$100,148.66
<table>
<thead>
<tr>
<th><strong>Unique CAT 3 ID:</strong></th>
<th><strong>Reference Number for RHP PP:</strong></th>
<th><strong>Other Outcome Improvement Target:</strong> Women returning for an annual mammogram per recommended screening guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>112672402.3.11</td>
<td>3.IT-12.6</td>
<td>TPI - 112672402</td>
</tr>
<tr>
<td><strong>Performing Provider Name:</strong> The University of Texas MD Anderson Cancer Center</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Related Category 1 or 2 Projects:**

<table>
<thead>
<tr>
<th><strong>Starting Point/Baseline:</strong></th>
<th><strong>Baseline in DY2 is 0; This tracking is not part of the existing Project VALET</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td>measure and monitor the provision of annual breast cancer screening services. In order to report accurate data and establish baselines, P-1 approached in DY2.</td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td><strong>Process Milestone 1 Estimated Incentive Payment:</strong> $49,589.66</td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td>month before their next annual screening mammogram. The MD Anderson Mobile Mammography Appointment line will also call women 24-hours prior to their scheduled mammogram. Both have been deemed as providing “strong evidence of their effectiveness in increasing breast cancer screening by mammography,” by The Guide to Community Preventive Services. <strong>Outcome Improvement Target Estimated Incentive Payment:</strong> $151,202.66</td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td>month before their next annual screening mammogram. The MD Anderson Mobile Mammography Appointment line will also call women 24-hours prior to their scheduled mammogram. Both have been deemed as providing “strong evidence of their effectiveness in increasing breast cancer screening by mammography,” by The Guide to Community Preventive Services. <strong>Outcome Improvement Target Estimated Incentive Payment:</strong> $470,307.33</td>
</tr>
</tbody>
</table>

**Process Milestone 2 [P-3]:** Develop and test data systems

**Metric 1 [P-3.1]:** Develop and test data system for tracking and reporting

d. **Data Source:** Develop and test data system for tracking and reporting

e. **Goals:** Completed data tracking system

f. **Rational/Evidence:** Process milestone P-3 was chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of annual breast cancer screening services. In order to report accurate data and establish baselines, P-3 must be approached in DY2.

**Process Milestone 2 Estimated Incentive Payment:** $49,589.66
<table>
<thead>
<tr>
<th><strong>Unique CAT 3 ID:</strong></th>
<th><strong>Reference Number for RHP PP:</strong></th>
<th><strong>Other Outcome Improvement Target: Women returning for an annual mammogram per recommended screening guidelines</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>112672402.3.11</td>
<td>3.IT-12.6</td>
<td>TPI - 112672402</td>
</tr>
<tr>
<td><strong>Performing Provider Name:</strong></td>
<td>The University of Texas MD Anderson Cancer Center</td>
<td></td>
</tr>
<tr>
<td><strong>Related Category 1 or 2 Projects:</strong></td>
<td>Unique Category 2 project identifier – 112672402.2.7</td>
<td></td>
</tr>
<tr>
<td><strong>Starting Point/Baseline:</strong></td>
<td>Baseline in DY2 is 0; This tracking is not part of the existing Project VALET</td>
<td></td>
</tr>
<tr>
<td><strong>Year 2</strong>&lt;br&gt;(10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 3</strong>&lt;br&gt;(10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 4</strong>&lt;br&gt;(10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 5</strong>&lt;br&gt;(10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Year 2 Estimated Outcome Amount:</strong>&lt;br&gt;$99,179.33</td>
<td><strong>Year 3 Estimated Outcome Amount:</strong> &lt;br&gt;$100,148.66</td>
<td><strong>Year 4 Estimated Outcome Amount:</strong> &lt;br&gt;$151,202.66</td>
</tr>
<tr>
<td><strong>Year 5 Estimated Outcome Amount:</strong>&lt;br&gt;$470,307.33</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</strong>&lt;br&gt;(add outcome amounts over DYs 2-5): $802,837.98</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Title of Outcome Measure (Improvement Target): IT-12.1 – Breast Cancer Screening (HEDIS 2012)

Unique RHP outcome identification number(s): 112672402.3.12

Outcome Measure Description:
IT-12.1 Breast Cancer Screening (HEDIS 2012)

Process Milestones:
- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:
- DY3: IT – 12.1 Number of women aged 40 to 69 that have received an annual mammogram during the reporting period – Improvement percent 166% from previous year
- DY4: IT – 12.1 Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period – Improvement percent 50% from previous year
- DY5: IT – 12.1 Number of women aged 40 to 69 that have received an annual mammogram during the reporting period – Improvement percent 25% from previous year

Rationale:
Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of breast cancer screening services. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

Improvement target percentages are based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the expansion period of a breast cancer screening program.

Outcome Measure Valuation:
We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.
**Unique CAT 3 ID:** 112672402.3.12  
**Reference Number for RHP PP:** 3.IT-12.1  
**Breast Cancer Screening (HEDIS 2012)**

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center  
**Related Category 1 or 2 Projects:**

<table>
<thead>
<tr>
<th>Year 2  (10/1/2012 – 9/30/2013)</th>
<th>Year 3  (10/1/2013 – 9/30/2014)</th>
<th>Year 4  (10/1/2014 – 9/30/2015)</th>
<th>Year 5  (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
</table>
| **Process Milestone 1** [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  
Metric 1 [P-1.1]: Meeting with participating clinic staff and program staff  
a. **Data Source:** Stakeholder meeting summaries; Staff meeting summaries  
b. **Goals:** One meeting per clinic  
c. **Rational/Evidence:** Process milestone P-1 was chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of breast cancer screening services. In order to report accurate data and establish baselines, P-1 must be approached in DY2.  
**Metric 2** [P-1.2]: Develop timeline and document implementation plan  
a. **Data Source:** Timeline and project implementation documents  
b. **Goals:** Develop one implementation plan  
c. **Rational/Evidence:** Process milestone P-1 was chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of breast cancer screening services. In order to report accurate data and establish baselines, P-1 must be approached in DY2.  
**Process Milestone 3 Estimated Incentive Payment:** $50,074.33  
**Outcome Improvement Target** [IT-12.1]: Breast Cancer Screening (HEDIS 2012)  
a. **Baseline:** 800 women screened per year with existing program/Goal: 1,200 women screened per year with expansion of Project VALET  
b. **Numerator:** Number of women, ages 40 to 69, who have received an annual mammogram during the reporting period  
c. **Denominator:** Number of women ages 40 to 60, who meet Project VALET’s eligibility  
**Data:** EHR reports/Patient records  
**Rational/Evidence:** Providing free screening mammograms to uninsured, low income and Medicaid eligible women, who meet the screening criteria is a prevention strategy which removes the financial and transportation barriers that typically prevent these women from getting screened. Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having | **Outcome Improvement Target** [IT-12.1]: Breast Cancer Screening (HEDIS 2012)  
a. **Baseline:** 1,200 women screened per year with existing program/Goal: 1,500 women screened per year with expansion of Project VALET  
b. **Numerator:** Number of women, ages 40 to 69, who have received an annual mammogram during the reporting period  
c. **Denominator:** Number of women ages 40 to 60, who meet Project VALET’s eligibility  
**Data:** EHR reports/Patient records  
**Rational/Evidence:** Providing free screening mammograms to uninsured, low income and Medicaid eligible women, who meet the screening criteria is a prevention strategy which removes the financial and transportation barriers that typically prevent these women from getting screened. Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having |
**Breast Cancer Screening (HEDIS 2012)**

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>measure and monitor the provision of breast cancer screening services. In order to report accurate data and establish baselines, P-1 must be approached in DY2.</td>
<td>ages 40 to 69, who have received an annual mammogram during the reporting period</td>
<td>unrecognized cancer. People with positive screening tests are subsequently referred to a program partner for diagnostic follow up by program navigators. Those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of unrecognized cancer. People with positive screening tests are subsequently referred to a program partner for diagnostic follow up by program navigators. Those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm, and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.</td>
<td>unrecognized cancer. People with positive screening tests are subsequently referred to a program partner for diagnostic follow up by program navigators. Those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm, and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.</td>
</tr>
</tbody>
</table>

**Process Milestone 1 Estimated Incentive Payment:** $49,589.66

**Process Milestone 2 [P-3]:** Develop and test data systems

**Metric 1 [P-2.1]:** Develop and test data system for tracking and reporting

a. **Data Source:** Develop and test data system for tracking and reporting

b. **Goals:** Completed data tracking system
c. **Rational/Evidence:** Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of breast cancer screening services. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

d. **Data/EHR reports/Patient records**

e. **Rational/Evidence:** Providing free screening mammograms to uninsured, low income and Medicaid eligible women, who meet the screening criteria is a prevention strategy which removes the financial and transportation barriers that typically prevent these women from getting screened. Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently referred to a program partner for diagnostic follow up by program navigators. Those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm, and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.

**Outcome Improvement Target Estimated Incentive Payment:** $151,202.66

**Process Milestone 2 Estimated Incentive Payment:** $49,589.66

**Outcome Improvement Target Estimated Incentive Payment:** $470,307.33
<table>
<thead>
<tr>
<th>Year</th>
<th>Baseline</th>
<th>Outcome Improvement Target</th>
<th>Estimated Incentive Payment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>Baseline is 300 women screened per year with existing program</td>
<td>and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm, and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.</td>
<td>$50,074.33</td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
<td></td>
<td>$99,179.33</td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
<td></td>
<td>$100,148.66</td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
<td></td>
<td>$151,202.66</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $802,837.98
University of Texas M.D. Anderson Cancer Center
Pass 2
**Category 3: Quality Improvements**

**Title of Outcome Measure (Improvement Target):**
IT-11.6 - Other Outcome Improvement Target (Smoking Cessation – Enroll in Treatment)

**Unique RHP outcome identification number(s):** 112672402.3.13/Pass 2

**Outcome Measure Description:**
IT-11.6 - Other Outcome Improvement Target (Smoking Cessation – Enroll in Treatment)
- Numerator: Number of patients who enroll in Quitline treatment after being connected to the Quitline

**Process Milestones:**
- **DY2:**
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans (protocol)
  - P-3 – Develop and test data systems
- **DY3:**
  - P-3 – Develop and test data systems

**Outcome Improvement Targets for each year:**
- **DY4: IT – 11.6**
  - Numerator: Number of Medicaid-eligible/indigent smokers who enroll in treatment with Quitline – Improvement percent: 35% (N=393)
  - Denominator: Number of Medicaid-eligible/indigent smokers who are connected with the Quitline
  - Data Source: Data from EHR and Alere reports

- **DY5: IT – 11.6**
  - Numerator: Number of Medicaid-eligible/indigent smokers who enroll in treatment with Quitline – Improvement percent: 35% (N=393 additional enrollments)
  - Denominator: Number of Medicaid-eligible/indigent smokers who are connected with the Quitline
  - Data Source: Data from EHR and Alere reports

**Rationale:**
The selected Category 3 Outcome Improvement Target is Medicaid-eligible/indigent smokers who enroll in treatment with the Quitline after being connected with the Quitline. Based on our previous experience with AAC, 35% of smokers connected with the Quitline will enroll in treatment.

Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of smoking cessation services provided to
smokers in FQHCs. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

This outcome measure corresponds to the overarching goal of the proposed project, to deliver evidence-based smoking cessation treatment to Medicaid-eligible/indigent smokers seeking care in FQHCs and to ultimately reduce tobacco-related morbidity and mortality, particularly among individuals who are disproportionately burdened with the disease.

**Outcome Measure Valuation:**
We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.
### Unique CAT 3 ID:
112672402.3.13 Pass 2

### Reference Number for RHP PP:
3.IT-11.6

### Other Outcome Improvement Target (Smoking Cessation – Enroll in Treatment)

### Performing Provider Name:
The University of Texas MD Anderson Cancer Center

### Related Category 1 or 2 Projects:
Unique Category 2 project identifier – 112672402.2.7

### Starting Point/Baseline:
Only one FQHC is currently implementing AAC. Smoking status, connection to treatment, and cessation outcomes are not currently, systematically collected in EHR.

### Year 2
(10/1/2012 – 9/30/2013)

**Process Milestone 1 [P-1]:** Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

**Metric 1 [P-1.1]:** Engage stakeholders at participating FQHCs

- Baseline/goal: Monthly meetings with participating FQHC leaders
- Data Source: EHR reports; Alere reports; Project database reports; Stakeholder meeting summaries; Staff meeting summaries
- Rationale: Stakeholders will be involved in AAC from the beginning and will help ensure that systems and processes are tailored for each clinic site.

**Process Milestone 1 Estimated Incentive Payment:** $12,621.33

### Year 3
(10/1/2013 – 9/30/2014)

**Process Milestone 3 [P-3]:** Develop and test data systems

**Metric 1 [P-1.1]:** Develop and test EHR enhancements

- Baseline/goal: Complete upgrades to EHR systems in each clinic
- Data Source: EHR reports; Alere reports; Project database reports; Stakeholder meeting summaries; Staff meeting summaries
- Rationale: AAC provides systems enhancements to electronic health records to capture data required for implementing tobacco clinical practice guidelines.

**Process Milestone 3 Estimated Incentive Payment:**

### Year 4
(10/1/2014 – 9/30/2015)

**Outcome Improvement Target [IT 11.6]:** Other Outcome Improvement Target (Smoking Cessation – Enroll in Treatment)

**Improvement Target:** Numerator: Number of Medicaid-eligible/indigent smokers who enroll in treatment with Quitline. Denominator: Number of Medicaid-eligible/indigent smokers connected to Quitline. – Improvement percent: 35% (N=393)

- Data Source: EHR reports; Alere reports
- Rationale: Based on previous AAC studies, approximately 35% of smokers connected to the Quitline enroll in treatment.

**Outcome Improvement Target Estimated Incentive Payment:**

### Year 5
(10/1/2015 – 9/30/2016)

**Outcome Improvement Target [IT 11.6]:** Other Outcome Improvement Target (Smoking Cessation – Enroll in Treatment)

**Improvement Target:** Numerator: Number of Medicaid-eligible/indigent smokers who enroll in treatment with Quitline. Denominator: Number of Medicaid-eligible/indigent smokers connected to Quitline. – Improvement percent: 35% (N=393 new enrollments)

- Data Source: EHR reports; Alere reports
- Rationale: Based on previous AAC studies, approximately 35% of smokers connected to the Quitline enroll in treatment.

**Outcome Improvement Target Estimated Incentive Payment:**
### Unique CAT 3 ID:
112672402.3.13 Pass 2

### Reference Number for RHP PP:
3.IT-11.6

### Other Outcome Improvement Target (Smoking Cessation – Enroll in Treatment)

#### Performing Provider Name:
The University of Texas MD Anderson Cancer Center

#### Related Category 1 or 2 Projects:
Unique Category 2 project identifier – 112672402.2.7

#### Starting Point/Baseline:
Only one FQHC is currently implementing AAC. Smoking status, connection to treatment, and cessation outcomes are not currently, systematically collected in EHR.

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

- **Incentive Payment:** $5,802.00
- **Process Milestone 2 [P-3]:** Develop and test data systems
- **Metric 2 [P-3.1]:** Develop and test EHR enhancements
  - Baseline/goal: Complete upgrades to EHR systems in each clinic
  - Data Source: EHR reports; Alere reports; Project database reports; Stakeholder meeting summaries; Staff meeting summaries
  - Rationale: AAC provides systems enhancements to electronic health records to capture data required for implementing tobacco clinical practice guidelines.

- **Process Milestone 2 Estimated Incentive Payment:** $5,802.00
- **Year 3 Incentive Payment:** $20,572.00
- **Year 4 Incentive Payment:** $60,994.66
<table>
<thead>
<tr>
<th>Performing Provider Name:</th>
<th>The University of Texas MD Anderson Cancer Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related Category 1 or 2 Projects:</td>
<td>Unique Category 2 project identifier – 112672402.2.7</td>
</tr>
<tr>
<td>Starting Point/Baseline:</td>
<td>Only one FQHC is currently implementing AAC. Smoking status, connection to treatment, and cessation outcomes are not currently, systematically collected in EHR.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Outcome Amount:</td>
<td>Year 2 $11,604.00</td>
<td>Year 3 $12,621.33</td>
<td>Year 4 $20,572.00</td>
<td>Year 5 $60,994.66</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5): $105,791.99*
Title of Outcome Measure (Improvement Target):

IT-11.6 - Other Outcome Improvement Target (Smoking Cessation – Make a Quit Attempt)

Unique RHP outcome identification number(s): 112672402.3.14 /Pass 2

Outcome Measure Description:
IT-11.6 - Other Outcome Improvement Target (Smoking Cessation – Make a Quit Attempt)
- Numerator: Number of Medicaid-eligible/indigent smokers enrolled in Quitline treatment that make a quit attempt

Process Milestones:
- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans (protocol)
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:
- DY4: IT – 11.6
  - Numerator: Number of Medicaid-eligible/indigent smokers enrolled in treatment that make a quit attempt – Improvement percent: 50% (N=196)
  - Denominator: Number of Medicaid-eligible/indigent smokers enrolled in treatment
  - Data Source: Data from EHR, Alere reports
- DY5: IT – 11.6
  - Numerator: Number of Medicaid-eligible/indigent smokers enrolled in treatment that make a quit attempt – Improvement percent: 50% (N=196 new quit attempts)
  - Denominator: Number of Medicaid eligible/indigent smokers enrolled in treatment
  - Data Source: Data from EHR, Alere reports

Rationale:
The selected Category 3 Outcome Improvement Target is Medicaid-eligible/indigent smokers enrolled in Quitline cessation treatment that make a quit attempt. At 6-months post completion of the cessation treatment, patients will be contacted by phone to assess smoking status. The SRNT Smoking Abstinence Questionnaire will be used. Based on our previous experience with AAC, at least 50% of smokers enrolled in Quitline treatment will make a quit attempt.

Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of smoking cessation services provided to smokers in FQHCs. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.
This outcome measure corresponds to the overarching goal of the proposed project, to deliver evidence-based smoking cessation treatment to smokers seeking care in FQHCs and to ultimately reduce tobacco-related morbidity and mortality, particularly among individuals who are disproportionately burdened with the disease.

**Outcome Measure Valuation:**
We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.
<table>
<thead>
<tr>
<th>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</th>
<th>Process Milestone 3 [P-3]: Develop and test data systems</th>
<th>Outcome Improvement Target [IT 11.6]: Other Outcome Improvement Target (Smoking Cessation – Make a Quit Attempt)</th>
<th>Outcome Improvement Target [IT 11.6]: Other Outcome Improvement Target (Smoking Cessation – Make a Quit Attempt)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metric 1 [P-1.1]: Engage stakeholders at participating FQHCs</td>
<td>Metric 1 [P-1.1]: Develop and test EHR enhancements</td>
<td>Improvement Target: Numerator: Number of Medicaid-eligible/indigent smokers enrolled in Quitline that make a quit attempt. Denominator: Number of Medicaid-eligible/indigent smokers enrolled in Quitline treatment. Improvement percent - 50% (N=196)</td>
<td>Improvement Target: Numerator: Number of Medicaid-eligible/indigent smokers enrolled in Quitline that make a quit attempt. Denominator: Number of Medicaid-eligible/indigent smokers enrolled in Quitline treatment. Improvement percent - 50% (N=196 new quit attempts)</td>
</tr>
<tr>
<td>Baseline/goal: Monthly meetings with participating FQHC leaders</td>
<td>Baseline/goal: Complete upgrades to EHR systems in each clinic</td>
<td>Data Source: EHR reports; Alere reports; Project database reports; Stakeholder meeting summaries; Staff meeting summaries</td>
<td>Data Source: EHR reports; Alere reports; self-report</td>
</tr>
<tr>
<td>Data Source: EHR reports; Alere reports; Project database reports; Stakeholder meeting summaries; Staff meeting summaries</td>
<td>Rationale: AAC provides systems enhancements to electronic health records to capture data required for implementing tobacco clinical practice guidelines.</td>
<td>Rationale: Based on previous AAC studies in similar populations, at least 50% of smokers enrolled in treatment</td>
<td>Rationale: Based on previous AAC studies in similar populations, at least 50% of smokers enrolled in treatment</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $5,802.00</td>
<td>Process Milestone 3 Estimated Incentive Payment: $12,621.33</td>
<td>Process Milestone 3 Estimated Incentive Payment:</td>
<td>Process Milestone 3 Estimated Incentive Payment:</td>
</tr>
</tbody>
</table>

Starting Point/Baseline: Only one FQHC is currently implementing AAC. Smoking status, connection to treatment, and cessation outcomes are not currently, systematically collected in EHR.
### Unique CAT 3 ID:

112672402.3.14 Pass 2

### Reference Number for RHP PP:
3.IT-11.6

### Other Outcome Improvement Target (Smoking Cessation – Make a Quit Attempt)

**Performing Provider Name:** The University of Texas MD Anderson Cancer Center

**Unique Category 2 project identifier –** 112672402.2.7

### Related Category 1 or 2 Projects:

**Starting Point/Baseline:**
Only one FQHC is currently implementing AAC. Smoking status, connection to treatment, and cessation outcomes are not currently, systematically collected in EHR.

<table>
<thead>
<tr>
<th>Year</th>
<th>Process Milestone 2 [P-3]: Develop and test data systems</th>
<th>Metric 2 [P-3.1]: Develop and test EHR enhancements</th>
<th>Baseline/goal: Complete upgrades to EHR systems in each clinic</th>
<th>Process Milestone 2 Estimated Incentive Payment:</th>
<th>Data Source: EHR reports; Alere reports; Project database reports; Stakeholder meeting summaries; Staff meeting summaries</th>
<th>Rationale: AAC provides systems enhancements to electronic health records to capture data required for implementing tobacco clinical practice guidelines.</th>
<th>Outcome Improvement Target Estimated Incentive Payment:</th>
<th>Estimated Incentive Payment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2</td>
<td>(10/1/2012 – 9/30/2013)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>make a quit attempt.</td>
<td>$20,572.00</td>
</tr>
<tr>
<td>Year 3</td>
<td>(10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>make a quit attempt.</td>
<td>$60,994.66</td>
</tr>
<tr>
<td>Year 4</td>
<td>(10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>make a quit attempt.</td>
<td>$20,572.00</td>
</tr>
<tr>
<td>Year 5</td>
<td>(10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>make a quit attempt.</td>
<td>$60,994.66</td>
</tr>
</tbody>
</table>

**Year 2 Estimated Outcome Amount:** $11,604.00

**Year 3 Estimated Outcome Amount:** $12,621.33

**Year 4 Estimated Outcome Amount:** $20,572.00

**Year 5 Estimated Outcome Amount:** $60,994.66

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $105,791.99
Title of Outcome Measure (Improvement Target): IT-11.6 (Smoking Cessation – Staying Quit)

Unique RHP outcome identification number(s): 112672402.3.15 Pass 2

Outcome Measure Description:

IT-11.6 - Other Outcome Improvement Target: Smoking Cessation – Staying Quit

- Numerator: Number of Medicaid-eligible/indigent smokers enrolled in Quitline treatment that are abstinent at 6 month follow-up

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans (protocol)
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4: IT – 11.6
  - Numerator: Number of Medicaid-eligible/indigent smokers enrolled in treatment that are abstinent at 6 month follow-up – Improvement percent: 28% (N=110)
  - Denominator: Number of Medicaid-eligible/indigent smokers enrolled in treatment
  - Data Source: Data from EHR and Alere reports, expired CO and self-report data collected from participants and stored in program databases.

- DY5: IT – 11.6
  - Numerator: Number of Medicaid-eligible/indigent smokers enrolled in treatment that will be abstinent at the time of follow-up – Improvement percent: 28% (N=110 additional smokers abstain)
  - Denominator: Number of Medicaid-eligible/indigent smokers enrolled in treatment
  - Data Source: Data from EHR, Alere reports, expired CO and self-report data collected from participants and stored in program databases.

Rationale:

The selected Category 3 Outcome Improvement Target is Medicaid-eligible/indigent smokers enrolled in Quitline cessation treatment that will be abstinent at time of follow-up. At 6-months post completion of the cessation treatment, patients will be contacted by phone to assess smoking status. The SRNT Smoking Abstinence Questionnaire will be used. To confirm cessation, participants will be mailed a carbon monoxide test with a self-addressed envelope. Based on Quitline data and the literature, 28% of Medicaid-eligible/indigent smokers enrolled in Quitline treatment are abstinent at 6-month follow-up.

Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of smoking cessation services provided to...
smokers in FQHCs. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

This outcome measure corresponds to the overarching goal of the proposed project, to deliver evidence-based smoking cessation treatment to smokers seeking care in FQHCs and to ultimately reduce tobacco-related morbidity and mortality, particularly among individuals who are disproportionately burdened with the disease.

**Outcome Measure Valuation:**
We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting Point/Baseline:</td>
<td>Starting Point/Baseline:</td>
<td>Starting Point/Baseline:</td>
<td>Starting Point/Baseline:</td>
</tr>
<tr>
<td><strong>Process Milestone 1 [P-1]:</strong> Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</td>
<td><strong>Process Milestone 3 [P-3]:</strong> Develop and test data systems Metric 1 [P-1.1]: Develop and test EHR enhancements Baseline/goal: Complete upgrades to EHR systems in each clinic Data Source: EHR reports; Alere reports; Project database reports; Stakeholder meeting summaries; Staff meeting summaries Rationale: AAC provides systems enhancements to electronic health records to capture data required for implementing tobacco clinical practice guidelines.</td>
<td><strong>Outcome Improvement Target [IT-11.6] Other Outcome Improvement Target (Smoking Cessation – Staying Quit)</strong> Improvement Target: Numerator: Number of Medicaid-eligible/indigent smokers enrolled in Quitline cessation treatment that will be abstinent at time of follow-up. Denominator: Number of Medicaid-eligible/indigent smokers enrolled in Quitline. Improvement % - 28% (N=110) Data Source: EHR reports; Alere reports; self-report and CO test results in project databases Rationale: Based on Quitline data and the literature, 28% of Medicaid-eligible/indigent smokers enrolled in Quitline treatment are abstinent at 6-month follow-up.</td>
<td><strong>Outcome Improvement Target [IT-11.6] Other Outcome Improvement Target (Smoking Cessation – Staying Quit)</strong> Improvement Target: Numerator: Number of Medicaid-eligible/indigent smokers enrolled in Quitline cessation treatment that will be abstinent at time of follow-up. Denominator: Number of Medicaid-eligible/indigent smokers enrolled in Quitline. Improvement % - 28% (N=110 additional smokers abstain) Data Source: EHR reports; Alere reports; self-report and CO results in project databases Rationale: Based on Quitline data and the literature, 28% of Medicaid-eligible/indigent smokers enrolled in Quitline treatment are abstinent at 6-month follow-up.</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment: $5,802.00</td>
<td>Process Milestone 3 Estimated Incentive Payment: $12,621.33</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Rationale:** Stakeholders will be involved in AAC from the beginning and will help ensure that systems and processes are tailored for each clinic site.
<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

### Process Milestone 2 [P-3]: Develop and test data systems

**Metric 2 [P-3.1]: Develop and test EHR enhancements**

- **Baseline/goal:** Complete upgrades to EHR systems in each clinic
- **Data Source:** EHR reports; Alere reports; Project database reports; Stakeholder meeting summaries; Staff meeting summaries
- **Rationale:** AAC provides systems enhancements to electronic health records to capture data required for implementing tobacco clinical practice guidelines.

**Process Milestone 2 Estimated Incentive Payment:** $5,802.00

**Outcome Improvement Target Estimated Incentive Payment:**
- **Year 4:** $20,572.00
- **Year 5:** treatment are abstinent at 6-month follow-up.

**Outcome Improvement Target Estimated Incentive Payment:**
- **Year 4:** $20,572.00
- **Year 5:** $60,994.66

**Year 2 Estimated Outcome Amount:** $11,604.00

**Year 3 Estimated Outcome Amount:** $12,621.33

**Year 4 Estimated Outcome Amount:** $20,572.00

**Year 5 Estimated Outcome Amount:** $60,994.66

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYS 2-5):* $105,791.99
West Houston Medical Center
Pass 1
Title of Outcome Measure (Improvement Target):
OD-3: IT 3.3.1: Potentially Preventable Readmissions

Unique RHP outcome identification number(s): 094187402.3.1

Performing Provider Name/TPI: HCA - West Houston Medical Center TPI/094187402

Outcome Measure Description:
HCA chose this outcome to accompany its project to create a Senior Care Coordinator position in its West Houston facility, who will engage in senior patient navigation of the healthcare continuum. HCA believes one result of that project will be a reduction in potentially preventable readmissions (PPRs) for patients enrolled in the navigator program. HCA expects this result because improved access to primary and preventative care, support, and education are evidence-based methods for reducing deterioration of patients’ conditions upon discharge from an inpatient stay. Too often seniors do not have access to these services, and as a result their health outcomes are negatively impacted and the systemic cost of treating these patients in increased.

Process Milestones:
HCA chose its DY2 and DY3 process milestones in order to develop a system for measuring improvement and to establish a baseline by which to measure improvement in DYs 4-5.

Outcome Improvement Targets for each year:
HCA chose its improvement targets in order to measure the reduction in PPRs once the Senior Care Coordination program has gone into effect. The amount of improvement is TBD until DY3, when HCA will have established a baseline, and can determine a reasonable yet meaningful target for improvement.

Rationale:
HCA selected this outcome measure and improvement target because HCA has identified geriatric patients as one population with a high rate of PPRs. As of the second quarter of 2012, West Houston Medical Center had a 14.3% readmission rate for all cause readmissions within 30 days for the Medicare population for the previous twelve months. This rate represents a performance that is lower than the average for Medicare patients. HCA believes that improving the rate of PPRs will improve patient outcomes, and will reduce the cost of providing care to geriatric patients. The goals of the Waiver are to make healthcare more patient-centered, less episodic and more consistent, and to reduce the cost of care in order to provide services to the ever increasing population of Medicaid and uninsured patients requiring services. This outcome reflects each of these Waiver goals.

Outcome Measure Valuation:
The valuation of each HCA West Houston Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. HCA West Houston determined the value of this outcome by assessing the potential impact of increased availability of patient navigation services for geriatric patients. This project will require development of standardized protocols and procedures for identifying, tracking, and following up with geriatric patients.
in an effort to get the patients appropriate care in the appropriate setting. HCA West Houston expects that the associated Category 2 project, a global system to improve outcomes for geriatric patients, will require training to ensure that personnel are prepared to assist in the unique needs of the elderly population. In addition to patient benefits, projects that seek to increase access to ambulatory health care settings will result in an overall cost-savings to the healthcare delivery system. It is clear that the rising costs of healthcare must be curbed to maintain a stable delivery system. Region 3 is focused on getting patients out of the ED for non-acute conditions, and ensuring that each patient has the information and referrals necessary to be seen at a community primary care provider. The valuation also takes accounts for the emphasis that the Region 3 DSRIP work groups have placed on the expansion of access to care for seniors.
<table>
<thead>
<tr>
<th>094187402.3.1</th>
<th>IT-3.1</th>
<th>30 Day All Cause Potentially Preventable Admissions (for geriatric patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCA – West Houston Medical Center</strong></td>
<td>094187402.2.1</td>
<td>094187402</td>
</tr>
<tr>
<td><strong>Related Category 1 or 2 Projects:</strong></td>
<td><strong>Starting Point/Baseline:</strong></td>
<td><strong>Potentially Preventable Readmissions</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Year 2</strong></td>
<td><strong>Year 3</strong></td>
</tr>
<tr>
<td><strong>Process Milestone 1</strong></td>
<td><strong>Process Milestone 2</strong></td>
<td><strong>Outcome Improvement Target 1</strong>[IT 3.1] – All Cause, 30 day PPRs</td>
</tr>
<tr>
<td>[P-3]: Develop and test data systems: HCA will develop a method for identifying geriatric patients, measuring the rate of PPRs for these patients, and cross-referencing that data with patients enrolled in HCA’s new Senior Care Coordination program.</td>
<td>[P-2]: Establish a baseline – HCA will establish a baseline rate of 30 day PPRs for geriatric in-patients discharged from the hospital, for all causes, in order to measure progress going forward</td>
<td><strong>Improvement Target</strong>: Decrease the number of PPRs for geriatric patients treated at HCA’s West Houston facility by an amount TBD under baseline established in DY3.</td>
</tr>
<tr>
<td><strong>Data Source:</strong> Hospital data reports</td>
<td><strong>Data Source:</strong> Hospital records, EHR</td>
<td><strong>Data Source:</strong> Hospital admission records</td>
</tr>
<tr>
<td>Process Milestone 1 Estimated Incentive Payment <em>(maximum amount):</em> $379,176</td>
<td>Process Milestone 2 Estimated Incentive Payment: $439,514</td>
<td>Outcome Improvement Target 1 Estimated Incentive Payment: $705,267</td>
</tr>
<tr>
<td>Year 2 Estimated Outcome Amount: $379,176</td>
<td>Year 3 Estimated Outcome Amount: $439,514</td>
<td>Year 4 Estimated Outcome Amount: $705,267</td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add outcome amounts over DYs 2-5):* $3,210,466
Category IV
Narratives and Tables
El Campo Memorial Hospital
Category 4 Population-Focused Improvements - Narrative

Performing Provider Name: El Campo Memorial Hospital (ECMH)
Performing Provider TPI #: 131045004

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – The population at ECMH of the 8 measures listed under Domain 1 is not anticipated to be sufficiently large to produce statistically valid data. However, ECMH will report this information annually as required by HHSC since the definition of the terminology “sufficiently large” has not been defined at this time. ECMH expects that its implementation of the Patient Experience Training Program will have a positive impact on the number of potentially preventable admissions for patients by focusing on reducing patient anxiety and increasing patient compliance with discharge instructions and follow-up health care. It is expected that patients will become healthier which will minimize admissions.

- **Valuation Rationale/Justification** – The value ECMH placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Potentially preventable admissions negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing potentially preventable admissions at ECMH will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for potentially preventable admissions. ECMH values this reporting domain at $15,819 over DY 3-5, requiring local funding of $6,358.

Domain 2: 30-day readmissions (7 measures)

- **Description** – The population at ECMH of the 7 measures listed under Domain 2 is not anticipated to be sufficiently large to produce statistically valid data. However, ECMH will report this information annually as required by HHSC since the definition of the terminology “sufficiently large” has not been defined at this time. ECMH expects that its implementation of the Patient Experience Training Program will have a positive impact on the number of potentially preventable 30-day readmissions for patients by focusing on reducing patient anxiety and increasing patient compliance with discharge instructions and follow-up health care. If patients follow their recommended plan of care, it is expected that they are less likely to be readmitted within 30 days for the same condition.

- **Valuation Rationale/Justification** – The value ECMH placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Potentially preventable 30-day readmissions...
negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing 30-day admissions at ECMH will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for 30-day readmissions. ECMH values this reporting domain at $15,819 over DY 3-5, requiring local funding of $6,358.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – The population at ECMH of the 64 measures listed under Domain 3 is not anticipated to be sufficiently large to produce statistically valid data. However, ECMH will report this information annually as required by HHSC since the definition of the terminology “sufficiently large” has not been defined at this time. ECMH suffers from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain. However, ECMH is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Through the implementation of the Patient Experience Training Program, ECMH expects to reduce patient anxiety and increase patient compliance with discharge instructions and follow-up health care which is expected to improve patient satisfaction and ultimately health outcomes.

- **Valuation Rationale/Justification** – The value ECMH placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require ECMH to evaluate its own performance and will allow for organizational change that will be invaluable for ECMH’s patients. The goals of the Waiver are to reduce the cost of providing care and to improve patient health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. ECMH values this reporting domain at $10,925 over DY 3-5, requiring local funding of $4,391.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – ECMH will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well ECMH is serving its patients. How a patient perceives his/her care often affects that patient’s willingness to engage in follow-up, self-management and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. ECMH is committed to preventing this from happening. Additionally, medication management is a primary function that ECMH’s providers need to engage in with patients to avoid readmissions, complications and to promote improved health outcomes outside of the hospital setting. ECMH expects that its implementation of the Patient Experience Training Program will have a positive impact on patient satisfaction and medication management by focusing on reducing patient anxiety which is expected to increase patient compliance with discharge instructions, follow-up health care and living a healthy lifestyle.
The value ECMH placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from ECMH and how well ECMH performs its function of promoting medication management. The goals of the Waiver are to reduce the cost of providing care and to improve patient health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and improving patient satisfaction and medication management at ECMH will have a beneficial impact on individual patient outcomes and significantly reduce overall healthcare costs. ECMH values this reporting domain at $15,819 over DY 3-5, requiring local funding of $6,358.

**Domain 5: Emergency Department (1 measure)**

**Description** – ECMH will measure the admit decision time to ED departure for admitted patients. ECMH expects that its implementation of the Patient Experience Training Program will have a positive impact on established patients by reducing their anxiety and in turn increasing their healthcare compliance such as seeking preventative health care and living healthy lifestyles. This is expected to reduce the number of visits to the ED by established patients in the ECMH system which would in turn reduce the number of admissions from the ED and ultimately reduce overall healthcare costs.

**Valuation Rationale/Justification** – The value ECMH placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes and patient dissatisfaction. The goals of the Waiver are to reduce the cost of providing care and to improve patient health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. ECMH values this reporting domain at $15,820 over DY 3-5, requiring local funding of $6,360.
## Category 4: Population-Focused Measures

**El Campo Memorial Hospital / 131045004**

### Capability to Report Category 4
- **Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.

### Domain 1: Potentially Preventable Admissions (PPAs)
- **Planned Reporting Period:** 1 or 2
- **Domain 1 - Estimated Maximum Incentive Amount**
  - Year 2: $4,894
  - Year 3: $5,235
  - Year 4: $5,690

### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)
- **Planned Reporting Period:** 1 or 2
- **Domain 2 - Estimated Maximum Incentive Amount**
  - Year 2: $4,894
  - Year 3: $5,235
  - Year 4: $5,690

### Domain 3: Potentially Preventable Complications (PPCs)
- **Includes a list of 64 measures identified in the RHP Planning Protocol.**
- **Planned Reporting Period:** 1 or 2
- **Domain 3 - Estimated Maximum Incentive Amount**
  - Year 2: $5,235
  - Year 3: $5,690

### Domain 4: Patient Centered Healthcare
#### Patient Satisfaction - HCAHPS
- **Measurement period for report**
  - Year 2: October 1 – September 30
  - Year 3: October 1 – September 30
  - Year 4: October 1 – September 30
- **Planned Reporting Period:** 1 or 2
  - Year 2: 2
  - Year 3: 2
  - Year 4: 2

#### Medication Management
- **Measurement period for report**
  - Year 2: October 1 – September 30
  - Year 3: October 1 – September 30
  - Year 4: October 1 – September 30
- **Planned Reporting Period:** 1 or 2
  - Year 2: 2
  - Year 3: 2
  - Year 4: 2
- **Domain 4 - Estimated Maximum Incentive Amount**
  - Year 2: $4,894
  - Year 3: $5,235
  - Year 4: $5,690

### Domain 5: Emergency Department
- **Measurement period for report**
  - Year 2: October 1 – September 30
  - Year 3: October 1 – September 30
  - Year 4: October 1 – September 30
<table>
<thead>
<tr>
<th>Planned Reporting Period: 1 or 2</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td>$4,893</td>
<td>$5,236</td>
<td>$5,691</td>
</tr>
<tr>
<td>Grand Total Payments Across Category 4</td>
<td>$10,555</td>
<td>$24,469</td>
<td>$26,176</td>
</tr>
</tbody>
</table>
Gulf Coast Medical Center
Performing Provider Name: Gulf Coast Medical Center/178815001

Category 4 Project: Population-Focused Improvements

Category 4 Reporting Summary for Domain 1—Potentially Preventable Admissions

- In year 2 system capability to report Domain 1 will be submitted to HHSC.

- Domain 1-RD-1 Potentially Preventable Admissions
  - This performing provider will report on the eight (8) potentially preventable admissions as defined in the Category 4 population-focused improvements.
  - Findings for this domain will begin being reported to HHSC in year 3.
  - Domain Description: Potentially Preventable Admissions relates to this performing provider’s Category 1 Project (Establish Adult Inpatient Psychiatric Unit) in a variety of ways. Common diseases such as those included in this Domain affect individuals of all ages and are frequently a co morbidity of those individuals with mental illnesses. Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease and Hypertension are the diagnoses in this Domain that may have the greatest impact with regard to preventing admissions. Those patients with a mental disorder/s that are not under the care of a mental health practitioner and have medical co morbidities are at risk for non-compliance of their treatment plan which results in admission. With the availability of treatment for mental disorders through our project those patients with co morbidities are more likely to be compliant with treatment plans thus preventing an admission.
  - Expected improvement for DY2-DY5 is difficult to determine but it is anticipated to decrease the number of potentially preventable admissions of adult psychiatric patients that have received treatment and have additional medical co morbidities.
  - Domain Valuation:
    - The following valuation for this domain for DY3 through DY5 is as follows for a total of $79,500
      - DY 3 $24,500
      - DY 4 $27,500
      - DY 5 $27,500
    - Areas considered when determining valuation for this domain have been addressed in the domain description.
Performing Provider Name: Gulf Coast Medical Center/178815001

Category 4 Project: Population-Focused Improvements

Category 4 Reporting Summary for Domain 2—Potentially Preventable Readmissions—30 Days

- In year 2 system capability to report Domain 2 will be submitted to HHSC.

- Domain 2- RD-2 30 Day Readmissions
  - This performing provider will report on the seven (7) focus areas for 30 day readmissions.
  - Findings for this domain will begin being reported to HHSC in year 3.
  - Domain Description: 30 Day Readmissions relates to this performing provider’s Category 1 Project (Establish An Adult Inpatient Psychiatric Unit) similar to the relation outlined for potentially preventable admission. Individuals with mental health disorders that have not received treatment or are non-compliant with the treatment plan for the mental illness may also be non-complaint with the treatment plan for existing co-morbidities thus resulting in readmission. It is anticipated that the 30 readmission measure –behavioral health and substance abuse - will show the highest impact with regard to readmissions as a result of this performing provider’s Category 1 Project. This provider has selected the Category 3 Outcome Improvement IT-1.18 Follow up after Hospitalization for Mental Illness as it relates to the Category 1 Project. A baseline will be established in year 3 with improvement targets established for year 4 and 5 utilizing baseline findings.
  - Expected Improvement for Y2 to Y5 will be defined from baseline data for the target outcome specifically selected to measure outcomes for the providers Category 1 Project.
  - Domain Valuation:
    The following valuation for this domain for DY3 through DY5 is as follows for a total of $79,500.
    
    | Year | Amount |
    |------|--------|
    | DY 3 | $24,500|
    | DY 4 | $27,500|
    | DY 5 | $27,500|

    Areas considered when determining valuation for this domain have been addressed in the domain description.
Performing Provider Name: Gulf Coast Medical Center/178815001

Category 4 Project: Population-Focused Improvements

Category 4 Reporting Summary for Domain 3—Potentially Preventable Complications

- In year 3 system capability to report Domain 3 will be submitted to HHSC.

- Domain 3- RD-3 Potentially Preventable Complications
  - A total of 64 potentially preventable complications will be reported by Gulf Coast Medical Center.
  - Findings for this domain will begin being reported to HHSC in year 4.
  - Potentially Preventable Complications relates to our chosen Category 1 Project involving the establishment of an adult inpatient psychiatric unit. All patients admitted to the proposed unit that have existing co morbidities which are left untreated could possibly have resulting complications. Individuals admitted to the proposed psychiatric unit with co morbidities will receive treatment for their additional medical diagnoses to prevent potential complications.
  - Anticipated improvement in year Y3-Y5 is a decrease in the number of preventable complications.
  - Domain Valuation:
    - The following valuation for this domain for DY4 and DY5 is as follows for a total of $55,000.
    - DY 4 $27,500
    - DY 5 $27,500

Areas considered when determining valuation for this domain have been addressed in the domain description.
Performing Provider Name: Gulf Coast Medical Center/178815001

Category 4 Project: Population-Focused Improvements

Category 4 Reporting Summary for Domain 4 — Patient Centered Healthcare

- In year 2 system capability to report Domain 4 will be submitted to HHSC.

- Domain 4- RD-4 Patient Centered Healthcare
  - This performing provider will report on the two (2) patient-centered healthcare measures as defined in the Category 4 population-focused improvements.
    - Patient Satisfaction: The following themes will be reported to include your care from doctors, your care from nurses, the hospital environment and when you left the hospital.
      - Reporting will begin DY 2 with baseline targets from the acute care settings for this performing provider.
    - Medication Management: All patients discharged from the inpatient setting will be included in reporting of data from this measure. Two measures will be reported by this performing provider to include medications to be taken by the patient and medications not to be taken by the patient.
      - Reporting will begin DY 2 with baseline targets from the acute care settings for this performing provider.

- Domain Valuation:
  - The following valuation for this domain for DY3 through DY5 is as follows for a total of $79,500.
    - DY 3 $24,500
    - DY 4 $27,500
    - DY 5 $27,500

Areas considered when determining valuation for this domain have been addressed in the domain description.
Performing Provider Name: Gulf Coast Medical Center/178815001

Category 4 Project: Emergency Department

Category 4 Reporting Summary for Domain 5 — Patient Centered Healthcare

- In year 2 system capability to report Domain 5 will be submitted to HHSC.

- Domain 5 – RD-5 Emergency Department
  - This performing provider will report on admit decision time to ED departure time for admitted patients (NQF 497).
    - Decision time to transfer an emergency patient to another facility ie, decision to make the first call from arrival in transferring ED until call initiated.
    - Threshold of <1 hour for critical patients.
    - This domain does not relate to this performing provider Category 1 Project.

- Domain Valuation
  The following valuation for this domain for DY3 through DY 5 is as follows for a total of $79,500.
  - DY 3 $24,500
  - DY 4 $27,500
  - DY 5 $27,500

Areas considered when determining valuation for this domain have been addressed in the domain description.
### Category 4: Population-Focused Measures

**Gulf Coast Medical Center/178815001**

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Maximum Incentive Amount</td>
<td>$33,436</td>
</tr>
</tbody>
</table>

### Domain 1: Potentially Preventable Admissions (PPAs)

**Planned Reporting Period:** 1 or 2

<table>
<thead>
<tr>
<th>Milestone:</th>
<th>$24,500</th>
</tr>
</thead>
</table>

### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

**Planned Reporting Period:** 1 or 2

<table>
<thead>
<tr>
<th>Milestone:</th>
<th>$27,500</th>
</tr>
</thead>
</table>

### Domain 3: Potentially Preventable Complications (PPCs)

*Includes a list of 64 measures identified in the RHP Planning Protocol.*

**Planned Reporting Period:** 1 or 2

<table>
<thead>
<tr>
<th>Milestone:</th>
<th>$27,500</th>
</tr>
</thead>
</table>

### Domain 4: Patient Centered Healthcare

*Patient Satisfaction - HCAHPS*
### Planned Reporting Period: 1 or 2

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>October 1 thru September 30</th>
<th>October 1 thru September 30</th>
<th>October 1 thru September 30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 4 - Estimated Maximum Incentive Amount</td>
<td>$24,500</td>
<td>$27,500</td>
<td>$27,500</td>
</tr>
</tbody>
</table>

### Domain 5: Emergency Department

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>October 1 thru September 30</th>
<th>October 1 thru September 30</th>
<th>October 1 thru September 30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td>$24,500</td>
<td>$27,500</td>
<td>$27,500</td>
</tr>
</tbody>
</table>

### OPTIONAL Domain 6: Children and Adult Core Measures

**Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)**

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>October 1 thru September 30</th>
<th>October 1 thru September 30</th>
<th>October 1 thru September 30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

**Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)**

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>October 1 thru September 30</th>
<th>October 1 thru September 30</th>
<th>October 1 thru September 30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Domain 6 - Estimated Maximum Incentive Amount</td>
<td>$</td>
<td>24,500</td>
<td>$</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------</td>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>27,500</td>
<td>$</td>
<td>27,500</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Total Payments Across Category 4</td>
<td>33436 $</td>
<td>147,000</td>
<td>165,000 $</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan
Region 3
2728
Harris County Hospital District Ben Taub General Hospital
Category 4 Population-Focused Improvements - Narrative Template

Performing Provider Name: Harris Health System
Performing Provider TPI #: 133355104

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Harris Health System will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Harris Health System expects that expanding services into primary care clinics will reroute patients away from emergent and inpatient settings and allow for better optimization of care.

- **Valuation** – The Harris Health System placed an equal value on all domains reported based on the number of domains per distribution year. As the goal of the Waiver is to reduce cost, improve access, and improve quality outcomes, the Harris Health System will utilize the required Category 4 Population-Focused Improvements as an internal key indicator to drive strategy and review impact of all projects implemented. All initiatives submitted will have beneficial impacts on majority of the domains reported within an appropriate timeline identified.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Harris Health System will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Harris Health System expects that the assignment of clinical case managers upon discharge will increase patient access to follow-up care and support in the community, thereby preventing the likelihood of a preventable readmission.

- **Valuation** – The Harris Health System placed an equal value on all domains reported based on the number of domains per distribution year. As the goal of the Waiver is to reduce cost, improve access, and improve quality outcomes, the Harris Health System will utilize the required Category 4 Population-Focused Improvements as an internal key indicator to drive strategy and review impact of all projects implemented. All initiatives submitted will have beneficial impacts on majority of the domains reported within an appropriate timeline identified.
Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Harris Health System will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and Harris Health System is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Harris Health System expects that its expansion of primary care and follow-up of chronic diseases in the primary care setting will reduce the volume of unnecessary utilization of hospital services which can be associated with an unnecessary complication.

- **Valuation** – The Harris Health System placed an equal value on all domains reported based on the number of domains per distribution year. As the goal of the Waiver is to reduce cost, improve access, and improve quality outcomes, the Harris Health System will utilize the required Category 4 Population-Focused Improvements as an internal key indicator to drive strategy and review impact of all projects implemented. All initiatives submitted will have beneficial impacts on majority of the domains reported within an appropriate timeline identified.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Harris Health System will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient’s willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. Harris Health System is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital’s providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. Harris Health System expects improved patient satisfaction in the hospital setting and effective medication management protocols for patients to correlate with Harris Health System’s projects oriented toward expansion of primary care and optimization of chronic disease management.

- **Valuation** – The Harris Health System placed an equal value on all domains reported based on the number of domains per distribution year. As the goal of the Waiver is to reduce cost, improve access, and improve quality outcomes, the Harris Health System will utilize the required Category 4 Population-Focused Improvements as an internal key indicator to drive strategy and review impact of all projects implemented. All
initiatives submitted will have beneficial impacts on majority of the domains reported within an appropriate timeline identified.

Domain 5: Emergency Department (1 measure)

• **Description** – Harris Health System will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. Harris Health System will expand primary care to accommodate patients that utilize the emergency center for primary care. There will also be establishment of urgent care clinics for patients needing acute care after-hours.

• **Valuation** – The Harris Health System placed an equal value on all domains reported based on the number of domains per distribution year. As the goal of the Waiver is to reduce cost, improve access, and improve quality outcomes, the Harris Health System will utilize the required Category 4 Population-Focused Improvements as an internal key indicator to drive strategy and review impact of all projects implemented. All initiatives submitted will have beneficial impacts on majority of the domains reported within an appropriate timeline identified.
### Category 4: Population-Focused Measures

**Harris Health System (aka Harris County Hospital District) / 133355104**

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
</table>

**Capability to Report Category 4**

- **Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.

<table>
<thead>
<tr>
<th>Estimated Maximum Incentive Amount</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,321,905</td>
<td>$3,867,634</td>
<td>$3,862,369</td>
<td>$4,167,662</td>
<td>$4,502,847</td>
</tr>
</tbody>
</table>

**Domain 1: Potentially Preventable Admissions (PPAs)**

- **Planned Reporting Period:** 1 or 2

<table>
<thead>
<tr>
<th>Domain 1 - Estimated Maximum Incentive Amount</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,862,369</td>
<td>$4,167,662</td>
<td>$4,502,582</td>
<td>$4,502,847</td>
<td></td>
</tr>
</tbody>
</table>

**Domain 2: Potentially Preventable Readmissions (30-day readmission rates)**

- **Planned Reporting Period:** 1 or 2

<table>
<thead>
<tr>
<th>Domain 2 - Estimated Maximum Incentive Amount</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,862,369</td>
<td>$4,167,662</td>
<td>$4,502,582</td>
<td>$4,502,847</td>
<td></td>
</tr>
</tbody>
</table>

**Domain 3: Potentially Preventable Complications (PPCs)**

- **Includes a list of 64 measures identified in the RHP Planning Protocol.**

<table>
<thead>
<tr>
<th>Domain 3 - Estimated Maximum Incentive Amount</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>$4,167,662</td>
<td>$4,502,582</td>
<td>$4,502,847</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Domain 4: Patient Centered Healthcare**

**Patient Satisfaction - HCAHPS**

- **Measurement period for report:** Oct. 1 - Sept. 30

<table>
<thead>
<tr>
<th>Planned Reporting Period: 1 or 2</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------</td>
<td>-------------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>Measurement period for report</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain 4 - Estimated Maximum Incentive Amount</td>
<td>$3,862,369</td>
<td>$4,167,662</td>
<td>$4,502,582</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurement period for report</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td>$3,862,369</td>
<td>$4,167,662</td>
<td>$4,502,582</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPTIONAL Domain 6: Children and Adult Core Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)</td>
</tr>
<tr>
<td>Measurement period for report</td>
</tr>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
</tr>
<tr>
<td>Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)</td>
</tr>
<tr>
<td>Measurement period for report</td>
</tr>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
</tr>
<tr>
<td>Domain 6 - Estimated Maximum Incentive Amount</td>
</tr>
</tbody>
</table>

| Grand Total Payments Across Category 4 | $1,321,905 | $19,317,110 | $20,838,310 | $22,513,174 |
HCA Bayshore Hospital
Performing Provider Name: HCA Bayshore Medical Center (“Bayshore”)
Performing Provider TPI #: 020817501

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Bayshore will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Bayshore expects that its expansion of OB/GYN services in its community clinics will have a positive impact on the number of PPAs for women with manageable obstetric/gynecological conditions that can be treated and/or managed outside of the hospital setting with proper access to primary care. Additionally, the physicians providing the OB/GYN care can provide patients with detection and management of other conditions that lead to PPAs for clients who are otherwise unable to access primary care.

- **Valuation Rationale/Justification** – The value Bayshore placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in at Bayshore will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. Bayshore values this reporting domain at $663,020 over Demonstration Years 3-5, requiring local funding of $266,533.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Bayshore will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Bayshore expects that the use of telemedicine in HCA’s local EDs could lead to a reduction in PPRs for BH/SA patients because the project aims to place BH/SA patients into the appropriate care setting as quickly and effectively as possible. If these patients receive the care they
need during and after hospitalization, they are much less likely to be readmitted within 30 days for the same condition.

- **Valuation Rationale/Justification** - The value Bayshore placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs for Bayshore patients will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Bayshore values this reporting domain at $663,020 over Demonstration Years 3-5, requiring local funding of $266,533.

**Domain 3: Potentially Preventable Complications (64 measures)**

- **Description** – Bayshore will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and Bayshore is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated.

- **Valuation Rationale/Justification** - The value Bayshore placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital’s patients and the hospital’s operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Bayshore values this reporting domain at $457,913 over Demonstration Years 3-5, requiring local funding of $184,080.
Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Bayshore will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient’s willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. Bayshore is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital’s providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. Bayshore hopes that implementing the telepsychiatry into the local HCA facilities will improve satisfaction for BH/SA patients, who currently spend extended amounts of time in the ED when they seek services at the hospital.

- **Valuation Rationale/Justification** - The value Bayshore placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Bayshore and how well Bayshore performs its function of promoting medication management. Bayshore is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease and lack of care coordination for traditionally underserved patients in Houston is costly to patients’ health and to the delivery system, and Bayshore believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community. Bayshore values this reporting domain at $663,020 over Demonstration Years 3-5, requiring local funding of $266,533.

Domain 5: Emergency Department (1 measure)

- **Description** – Bayshore will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. Bayshore’s telepsychiatry project in the local HCA EDs will seek to improve the
admit decision time to ED departure time for BH/SA patients, who often wait days for appropriate placement due to a shortage of providers to perform assessments.

- **Valuation Rationale/Justification** - The value Bayshore placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Bayshore values this reporting domain at $663,018 over Demonstration Years 3-5, requiring local funding of $266,533.
<table>
<thead>
<tr>
<th>Category 4: Population-Focused Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bayshore Medical Center - 020817501</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capability to Report Category 4</th>
<th>Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Maximum Incentive Amount</td>
<td>$442,371</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 1: Potentially Preventable Admissions (PPAs)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Domain 1 - Estimated Maximum Incentive Amount</td>
<td>$205,107</td>
<td>$219,417</td>
<td>$238,496</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 2: Potentially Preventable Readmissions (30-day readmission rates)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Domain 2 - Estimated Maximum Incentive Amount</td>
<td>$205,107</td>
<td>$219,417</td>
<td>$238,496</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 3: Potentially Preventable Complications (PPCs)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Domain 3 - Estimated Maximum Incentive Amount</td>
<td>$219,417</td>
<td>$238,496</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 4: Patient Centered Healthcare</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction - HCCHPS</td>
<td>Measurement period for report</td>
<td>October 1 - September 30</td>
<td>October 1 - September 31</td>
</tr>
<tr>
<td>Medication Management</td>
<td>Measurement period for report</td>
<td>October 1 - September 30</td>
<td>October 1 - September 30</td>
</tr>
<tr>
<td>Domain 4 - Estimated Maximum Incentive Amount</td>
<td>$205,107</td>
<td>$219,417</td>
<td>$238,496</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 5: Emergency Department</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurement period for report</td>
<td>October 1 - September 30</td>
<td>October 1 - September 30</td>
<td>October 1 - September 30</td>
</tr>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td>$205,107</td>
<td>$219,417</td>
<td>$238,495</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPTIONAL: Domain 6: Children and Adult Core Measures</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)</td>
<td>Measurement period for report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)</td>
<td>Measurement period for report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain 6 - Estimated Maximum Incentive Amount</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

| Grand Total Payments Across Category 4 | $442,371 | $1,025,534 | $1,097,083 | $1,192,480 |

---

**Month October 2012 - September 30 2013**

- **Domain 1:** Potentially Preventable Admissions
  - Measurement period: October 1 - September 30
  - Estimated Maximum Incentive Amount: $205,107

- **Domain 2:** Potentially Preventable Readmissions
  - Measurement period: October 1 - September 30
  - Estimated Maximum Incentive Amount: $219,417

- **Domain 3:** Potentially Preventable Complications
  - Included a list of 64 measures identified in the RHP Planning Protocol.
  - Measurement period: October 1 - September 30
  - Estimated Maximum Incentive Amount: $238,496

- **Domain 4:** Patient Centered Healthcare
  - Measurement period: October 1 - September 30
  - Estimated Maximum Incentive Amount: $238,495

- **Domain 5:** Emergency Department
  - Measurement period: October 1 - September 30
  - Estimated Maximum Incentive Amount: $238,495

- **OPTIONAL: Domain 6:** Children and Adult Core Measures
  - Measurement period: October 1 - September 30
  - Estimated Maximum Incentive Amount: $238,495

---

**Month October 2013 - September 30 2014**

- **Domain 1:** Potentially Preventable Admissions
  - Measurement period: October 1 - September 30
  - Estimated Maximum Incentive Amount: $205,107

- **Domain 2:** Potentially Preventable Readmissions
  - Measurement period: October 1 - September 30
  - Estimated Maximum Incentive Amount: $219,417

- **Domain 3:** Potentially Preventable Complications
  - Estimated Maximum Incentive Amount: $238,496

- **Domain 4:** Patient Centered Healthcare
  - Estimated Maximum Incentive Amount: $238,495

- **Domain 5:** Emergency Department
  - Estimated Maximum Incentive Amount: $238,495

- **OPTIONAL: Domain 6:** Children and Adult Core Measures
  - Estimated Maximum Incentive Amount: $238,495

---

**Month October 2014 - September 30 2015**

- **Domain 1:** Potentially Preventable Admissions
  - Measurement period: October 1 - September 30
  - Estimated Maximum Incentive Amount: $205,107

- **Domain 2:** Potentially Preventable Readmissions
  - Measurement period: October 1 - September 30
  - Estimated Maximum Incentive Amount: $219,417

- **Domain 3:** Potentially Preventable Complications
  - Estimated Maximum Incentive Amount: $238,496

- **Domain 4:** Patient Centered Healthcare
  - Estimated Maximum Incentive Amount: $238,495

- **Domain 5:** Emergency Department
  - Estimated Maximum Incentive Amount: $238,495

- **OPTIONAL: Domain 6:** Children and Adult Core Measures
  - Estimated Maximum Incentive Amount: $238,495

---

**Month October 2015 - September 30 2016**

- **Domain 1:** Potentially Preventable Admissions
  - Measurement period: October 1 - September 30
  - Estimated Maximum Incentive Amount: $205,107

- **Domain 2:** Potentially Preventable Readmissions
  - Measurement period: October 1 - September 30
  - Estimated Maximum Incentive Amount: $219,417

- **Domain 3:** Potentially Preventable Complications
  - Estimated Maximum Incentive Amount: $238,496

- **Domain 4:** Patient Centered Healthcare
  - Estimated Maximum Incentive Amount: $238,495

- **Domain 5:** Emergency Department
  - Estimated Maximum Incentive Amount: $238,495

- **OPTIONAL: Domain 6:** Children and Adult Core Measures
  - Estimated Maximum Incentive Amount: $238,495
HCA West Houston Medical Center
Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – WHMC will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. WHMC expects that assigning care coordinators to seniors who visit WHMC through its Category 1 project will result in senior patients receiving expanded primary care services in the community, reducing the number of PPAs going forward for those patients. More specifically, WHMC hopes that senior patients with chronic diseases will be better able to engage in self-management goals and activities of daily living with the support, education, and services that primary care providers participating with WHMC in this project can offer to a currently underserved patient population.

- **Valuation Rationale/Justification** – The value WHMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in at WHMC will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. WHMC values this reporting domain at $284,151 over Demonstration Years 3-5, requiring local funding of $114,228.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – WHMC will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. WHMC expects that the assignment of senior hospital patients to Senior Care Coordinators upon discharge will increase their access to follow-up care and support in the community, thereby
preventing the likelihood of a PPR. WHMC’s Category 3 Outcome is based upon accomplishing a percentage reduction in the number of PPRs for geriatric patients by the end of DY5, by a percentage to be established in DY3.

- **Valuation Rationale/Justification** - The value WHMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs for WHMC patients will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. WHMC values this reporting domain at $284,151 over Demonstration Years 3-5, requiring local funding of $114,228.

**Domain 3: Potentially Preventable Complications (64 measures)**

- **Description** – WHMC will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and WHMC is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. WHMC expects that its Category 1 project to add a “Senior Care Entrance” to the hospital and provide special beds for geriatric patients will have a positive impact on the PPC rate for the geriatric population seen in the hospital.

- **Valuation Rationale/Justification** - The value WHMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital’s patients and the hospital’s operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. WHMC values this reporting domain at $196,248 over Demonstration Years 3-5, requiring local funding of $78,891.
Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – WHMC will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient’s willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. WHMC is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital’s providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. WHMC expects improved patient satisfaction in the hospital setting and effective medication management protocols for seniors to correlate with WHMC’s Category 1 project to provide geriatric-oriented hospital accommodations and care coordination.

- **Valuation Rationale/Justification** - The value WHMC placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from WHMC and how well WHMC performs its function of promoting medication management. WHMC is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease and lack of care coordination for traditionally underserved patients (such as the elderly) in Houston is costly to patients’ health and to the delivery system, and WHMC believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community. WHMC values this reporting domain at $284,151 over Demonstration Years 3-5, requiring local funding of $114,228.

Domain 5: Emergency Department (1 measure)

- **Description** – WHMC will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments,
and other types of providers, and the patients experience poor health outcomes as a result.

- **Valuation Rationale/Justification** - The value WHMC placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. WHMC values this reporting domain at $284,151 over Demonstration Years 3-5, requiring local funding of $114,228.
## Capability to Report Category 4

**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.

### Estimated Maximum Incentive Amount

<table>
<thead>
<tr>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Planned Reporting Period:</strong> 1 or 2</td>
<td><strong>Planned Reporting Period:</strong> 1 or 2</td>
<td><strong>Includes a list of 64 measures identified in the RHP Planning Protocol.</strong></td>
<td><strong>Patient Satisfaction - HCAHPS</strong></td>
</tr>
<tr>
<td><strong>Domain 1 - Estimated Maximum Incentive Amount</strong></td>
<td><strong>Domain 2 - Estimated Maximum Incentive Amount</strong></td>
<td><strong>Domain 3 - Estimated Maximum Incentive Amount</strong></td>
<td><strong>Domain 4 - Estimated Maximum Incentive Amount</strong></td>
</tr>
<tr>
<td><strong>$189,588</strong></td>
<td><strong>$87,903</strong></td>
<td><strong>$94,036</strong></td>
<td><strong>$102,212</strong></td>
</tr>
<tr>
<td>$87,903</td>
<td>$94,036</td>
<td>$102,212</td>
<td>$102,212</td>
</tr>
</tbody>
</table>

**West Houston Medical Center - 094187402**
<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>1</th>
<th>1</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>October 1 - September 30</td>
<td>October 1 - September 31</td>
<td>October 1 - September 30</td>
</tr>
</tbody>
</table>

**Medication Management**

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>1</th>
<th>1</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain 4 - Estimated Maximum Incentive Amount</td>
<td>$87,903</td>
<td>$94,036</td>
<td>$102,212</td>
</tr>
</tbody>
</table>

**Domain 5: Emergency Department**

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>1</th>
<th>1</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td>$87,903</td>
<td>$94,035</td>
<td>$102,213</td>
</tr>
</tbody>
</table>

**OPTIONAL Domain 6: Children and Adult Core Measures**

- **Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)**
  - Measurement period for report
  - Planned Reporting Period: 1 or 2
- **Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)**
  - Measurement period for report
  - Planned Reporting Period: 1 or 2
<table>
<thead>
<tr>
<th>Domain 6 - Estimated Maximum Incentive Amount</th>
<th></th>
<th>$</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Total Payments Across Category 4</td>
<td>189588</td>
<td>$</td>
<td>439,515</td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan Region 3 2748
Matagorda Regional Medical Center
Performing Provider Name: Matagorda Regional Medical Center (MRMC)
Performing Provider TPI #: 1679678767

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – MRMC will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. MRMC expects that its establishment of a Chronic Disease Specialty Clinic (CDSC) in its community will have a positive impact on the number of PPAs for patients with chronic disease conditions by focusing on providing access to specialty services and physicians that support care for a number of key chronic conditions. Through the establishment of the CDSC, patient compliance with specialty referral visits will improve and the ability to manage chronic disease conditions on an ambulatory basis will improve.

- **Valuation Rationale/Justification** – The value MRMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs at MRMC will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. MRMC values this reporting domain at $92,230 over Demonstration Years 3-5, requiring local funding of $37,076.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – MRMC will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. MRMC expects that the establishment of the Chronic Disease Specialty Clinic (CDSC) will provide a centralized location for determining best practice management of patients with the targeted disease categories. By creating the clinic with the respective specialists, information systems and care coordination will allow patients and their primary care providers to have ready access to expertise that will reduce issues with noncompliance, reduce out of control health crises, and therefore reduce hospital readmissions and unnecessary visits to the emergency department. If these patients receive the care they need during and after hospitalization, they are much less likely to be readmitted within 30 days for the same condition.

- **Valuation Rationale/Justification** - The value MRMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-
day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs for MRMC patients will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. MRMC values this reporting domain at $92,231 over Demonstration Years 3-5, requiring local funding of $37,077.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – MRMC will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and MRMC is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. MRMC through the Chronic Disease Speciality Clinic (CDSC) will strive to transform the health care delivery from a disease focused model of episodic care to a patient-centered coordinated delivery model that improves patient satisfaction and health outcomes.

- **Valuation Rationale/Justification** - The value MRMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital’s patients and the hospital’s operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. MRMC values this reporting domain at $63,699 over Demonstration Years 3-5, requiring local funding of $25,607.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – MRMC will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient’s willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. MRMC is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital’s providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. MRMC hopes that implementing the Chronic Disease Speciality Clinic will improve satisfaction for MRMC patients, by coordinating care with providing access and early intervention and preventing patients from getting “lost” in the health care system.

- **Valuation Rationale/Justification** - The value MRMC placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive
from MRMC and how well MRMC performs its function of promoting medication management. MRMC is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease and lack of care coordination for traditionally underserved patients in Matagorda County is costly to patients’ health and to the delivery system, and MRMC believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary and specialty care to have the maximum beneficial impact for the community. MRMC values this reporting domain at $92,231 over Demonstration Years 3-5, requiring local funding of $37,077.

**Domain 5: Emergency Department (1 measure)**

- **Description** – MRMC will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. MRMC’s Chronic Disease Speciality Clinic project will assist ED providers by decreasing the number of disease related crisis visits to the ED and transforming care for the targeted populations from one of fragmented resources to an organized system of followup for primary and specialty services. MRMC will seek to improve the admit decision time to ED departure time for MRMC patients, who often wait days for appropriate placement due to a shortage of providers to perform assessments.

- **Valuation Rationale/Justification** - The value MRMC placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. MRMC values this reporting domain at $92,231 over Demonstration Years 3-5, requiring local funding of $37,077.
## Category 4: Population-Focused Measures

Matagorda County Hospital District (dba/Matagorda Regional Medical Center)/TPI #130959304

### Capability to Report Category 4

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Estimated Maximum Incentive Amount</strong></td>
<td><strong>$101,528</strong></td>
</tr>
</tbody>
</table>

### Domain 1: Potentially Preventable Admissions (PPAs)

<table>
<thead>
<tr>
<th>Planned Reporting Period: 1 or 2</th>
<th>1</th>
<th>1</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 1 - Estimated Maximum Incentive Amount</strong></td>
<td><strong>$47,648</strong></td>
<td><strong>$51,364</strong></td>
<td><strong>$55,734</strong></td>
</tr>
</tbody>
</table>

### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

<table>
<thead>
<tr>
<th>Planned Reporting Period: 1 or 2</th>
<th>1</th>
<th>1</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 2 - Estimated Maximum Incentive Amount</strong></td>
<td><strong>$47,649</strong></td>
<td><strong>$51,365</strong></td>
<td><strong>$55,734</strong></td>
</tr>
</tbody>
</table>

### Domain 3: Potentially Preventable Complications (PPCs)

Includes a list of 64 measures identified in the RHP Planning Protocol.

<table>
<thead>
<tr>
<th>Planned Reporting Period: 1 or 2</th>
<th>1</th>
<th>1</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain 3 - Estimated Maximum Incentive Amount</strong></td>
<td><strong>$51,364</strong></td>
<td><strong>$55,734</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Domain 4: Patient Centered Healthcare

**Patient Satisfaction - HCAHPS**
<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>DY 2</th>
<th>DY 3</th>
<th>DY 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**Medication Management**

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>DY 2</th>
<th>DY 3</th>
<th>DY 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

| Domain 4 - Estimated Maximum Incentive Amount | $     | $47,648 | $      | $51,364 | $      | $55,736 |

*Regional Healthcare Partnership Plan*

Region 3

2754
### Domain 5: Emergency Department

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>DY 2</th>
<th>DY 3</th>
<th>DY 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td>$ 47,648</td>
<td>$ 51,364</td>
<td>$ 55,736</td>
</tr>
</tbody>
</table>

### OPTIONAL Domain 6: Children and Adult Core Measures

- **Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)**
  - Measurement period for report
  - Planned Reporting Period: 1 or 2

- **Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)**
  - Measurement period for report
  - Planned Reporting Period: 1 or 2

<table>
<thead>
<tr>
<th>Domain 6 - Estimated Maximum Incentive Amount</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Grand Total Payments Across Category 4</th>
<th>$ 101,528</th>
<th>$ 238,241</th>
<th>$ 256,821</th>
</tr>
</thead>
</table>

278,674
Memorial Hermann Hospital
Category 4 Population-Focused Improvements - Narrative Template

Performing Provider Name: Memorial Hermann Hospital  
Performing Provider TPI #: 137805107

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Memorial Hermann Hospital (“Memorial”) will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Memorial plans to implement Category 1 DSRIP projects with the goal of addressing the root causes of potentially preventable admissions. Specifically, this project will expand regional primary care capacity by establishing primary care clinics. Memorial expects that this project will reduce potentially preventable admissions by making it easier for more patients to receive the primary care they need in appropriate outpatient settings rather than inpatient or emergent settings. Memorial also believes that the increased availability of primary care services in the community will allow potentially harmful and expensive health conditions to be detected and treated early and inexpensively.

- **Valuation Rationale/Justification** – The value Memorial has placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs at Memorial will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. Memorial values this reporting domain at $2,497,998 over Demonstration Years 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Memorial will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Memorial expects that its improvement of access to primary care services through establishing additional primary care clinics will allow patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR.

- **Valuation Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases (e.g., diabetes and congestive heart failure) and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in
conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs at Memorial will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Memorial values this reporting domain at $2,497,998 over Demonstration Years 3-5.

**Domain 3: Potentially Preventable Complications (64 measures)**
- **Description** – Memorial will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and Memorial is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Memorial expects that its expanded provision of primary care and of follow-up care for chronic diseases will reduce the volume of unnecessary utilization of hospital services, thus alleviating one of the problems which can result in unnecessary complications for inpatients. The ongoing quality improvement activities which constitute an essential part of Memorial’s Category 3 projects will also help to ensure that error rates and complications are reduced at all levels of care throughout Memorial.

- **Valuation Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital’s patients and the hospital’s operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Memorial values this reporting domain at $1,724,544 over Demonstration Years 3-5.

**Domain 4: Patient-Centered Healthcare (2 measures)**
- **Description** – Memorial will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient’s willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. Memorial is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital’s providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. Memorial expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with Memorial’s projects to strengthen primary care access in the community and to promote and facilitate management of chronic conditions, because satisfied patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management).
• **Valuation Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Memorial and how well Memorial performs its primary care and post-discharge functions. Memorial is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease in our community is costly to patients’ health and to the delivery system, and Memorial believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community. Memorial values this reporting domain at $2,497,998 over Demonstration Years 3-5.

**Domain 5: Emergency Department (1 measure)**

• **Description** – Memorial will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. This reporting domain ties in with one of the overall aims of the waiver: to reduce inappropriate use of the ED. One cause of extended ED departure times results from an overcrowded ED. Memorial intends to expand access to primary care for patients who currently are unable to access primary care due to factors such as the lack of primary care providers in the community, and to improve follow-up care for discharged patients diagnosed with chronic health conditions, which Memorial expects will reduce the number of inappropriate ED visits and therefore allow for better management of ED processes such as admit decisions.

• **Valuation Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Memorial values this reporting domain at $2,497,998 over Demonstration Years 3-5.
**Category 4 Table:** The RHP plan shall include the planned semi-annual reporting period, 1 (October 1 – March 31) or 2 (April 1 – September 30) for each domain or measure.

- **DY 2 incentive payments are for submission to HHSC of a status report that describes the system changes the hospital is putting in place to prepare to successfully report Category 4 measures in DYS 3-5.**
- **Category 4 reporting shall begin in DY 3 for Domains 1, 2, 4, 5, and 6 (optional), in DY 4 for Domain 3, and continue for all Domains through DY 5.**

### Category 4: Population-Focused Measures
**Memorial Hermann Hospital – TPI: 137805107**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Estimated Maximum Incentive Amount</strong></td>
<td>$1,668,256</td>
<td>$773,454</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Domain 1: Potentially Preventable Admissions (PPAs)

- **Planned Reporting Period: 1 or 2**
  - 1
  - 1
  - 1

- **Domain 1 - Estimated Maximum Incentive Amount**
  - $773,454
  - $827,043
  - $897,501

#### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

- **Planned Reporting Period: 1 or 2**
  - 1
  - 1
  - 1

- **Domain 2 - Estimated Maximum Incentive Amount**
  - $773,454
  - $827,043
  - $897,501

#### Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.

- **Planned Reporting Period: 1 or 2**
  - 1
  - 1

- **Domain 3 - Estimated Maximum Incentive Amount**
  - $827,043
  - $897,501

#### Domain 4: Patient Centered Healthcare

- **Patient Satisfaction - HCAHPS**
  - Measurement period for report
    - Oct. 1 – Sept. 30
    - Oct. 1 – Sept. 30
    - Oct. 1 – Sept. 30
  - Planned Reporting Period: 1 or 2
    - 1
    - 1
    - 1

- **Medication Management**
  - Measurement period for report
    - Oct. 1 – Sept. 30
    - Oct. 1 – Sept. 30
    - Oct. 1 – Sept. 30
  - Planned Reporting Period: 1 or 2
    - 1
    - 1
    - 1
| Domain 4 - Estimated Maximum Incentive Amount | $827,043 | $897,501 | $897,501 |
| Domain 5: Emergency Department | | | |
| Planned Reporting Period: 1 or 2 | 1 | 1 | 1 |
| Domain 5 - Estimated Maximum Incentive Amount | $773,454 | $827,043 | $897,501 |
| OPTIONAL Domain 6: Children and Adult Core Measures | | | |
| Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (5 measures) | | | |
| Planned Reporting Period: 1 or 2 | 1 | 1 | 1 |
| Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (8 measures) | | | |
| Planned Reporting Period: 1 or 2 | N/A | N/A | N/A |
| Domain 6 - Estimated Maximum Incentive Amount | | | |
| Grand Total Payments Across Category 4 | $1,668,256 | $3,867,270 | $4,135,215 | $4,487,505 |
Memorial Hermann Hospital System
Category 4 Population-Focused Improvements - Narrative Template

Performing Provider Name: Memorial Hermann Hospital System
Performing Provider TPI #: 020834001

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Memorial Hermann Hospital System (“Memorial”) will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Memorial plans to implement Category 1 DSRIP projects with the goal of addressing the root causes of potentially preventable admissions. Specifically, this project will expand regional primary care capacity by establishing primary care clinics. Memorial expects that this project will reduce potentially preventable admissions by making it easier for more patients to receive the primary care they need in appropriate outpatient settings rather than inpatient or emergent settings. Memorial also believes that the increased availability of primary care services in the community will allow potentially harmful and expensive health conditions to be detected and treated early and inexpensively.

- **Valuation Rationale/Justification** – The value Memorial has placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs at Memorial will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. Memorial values this reporting domain at $2,446,921 over Demonstration Years 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Memorial will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Memorial expects that its improvement of access to primary care services through establishing additional primary care clinics will allow patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR.

- **Valuation Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases (e.g., diabetes and congestive heart failure) and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in
conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs at Memorial will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Memorial values this reporting domain at $2,446,921 over Demonstration Years 3-5.

**Domain 3: Potentially Preventable Complications (64 measures)**
- **Description** – Memorial will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and Memorial is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Memorial expects that its expanded provision of primary care and of follow-up care for chronic diseases will reduce the volume of unnecessary utilization of hospital services, thus alleviating one of the problems which can result in unnecessary complications for inpatients. The ongoing quality improvement activities which constitute an essential part of Memorial’s Category 3 projects will also help to ensure that error rates and complications are reduced at all levels of care throughout Memorial.

- **Valuation Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital’s patients and the hospital’s operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Memorial values this reporting domain at $1,690,652 over Demonstration Years 3-5.

**Domain 4: Patient-Centered Healthcare (2 measures)**
- **Description** – Memorial will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient’s willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. Memorial is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital’s providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. Memorial expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with Memorial’s projects to strengthen primary care access in the community and to promote and facilitate management of chronic conditions, because satisfied patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management).
• **Valuation Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Memorial and how well Memorial performs its primary care and post-discharge functions. Memorial is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease in our community is costly to patients’ health and to the delivery system, and Memorial believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community. Memorial values this reporting domain at $2,446,921 over Demonstration Years 3-5.

**Domain 5: Emergency Department (1 measure)**

• **Description** – Memorial will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. This reporting domain ties in with one of the overall aims of the waiver: to reduce inappropriate use of the ED. One cause of extended ED departure times results from an overcrowded ED. Memorial intends to expand access to primary care for patients who currently are unable to access primary care due to factors such as the lack of primary care providers in the community, and to improve follow-up care for discharged patients diagnosed with chronic health conditions, which Memorial expects will reduce the number of inappropriate ED visits and therefore allow for better management of ED processes such as admit decisions.

• **Valuation Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Memorial values this reporting domain at $2,446,921 over Demonstration Years 3-5.
**Category 4 Table:** The RHP plan shall include the planned semi-annual reporting period, 1 (October 1 – March 31) or 2 (April 1 – September 30) for each domain or measure.
- **DY 2 incentive payments are for submission to HHSC of a status report that describes the system changes the hospital is putting in place to prepare to successfully report Category 4 measures in DYs 3-5.**
- **Category 4 reporting shall begin in DY 3 for Domains 1, 2, 4, 5, and 6 (optional), in DY 4 for Domain 3, and continue for all Domains through DY 5.**

### Category 4: Population-Focused Measures
**Memorial Hermann Hospital System – TPI: 020834001**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Estimate Maximum Incentive Amount</strong></td>
<td>$1,631,034</td>
<td>$756,269</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Domain 1: Potentially Preventable Admissions (PPAs)
- **Planned Reporting Period:** 1 or 2
- **Domain 1 - Estimated Maximum Incentive Amount**
  - Year 2: $756,269
  - Year 3: $809,405
  - Year 4: $881,247

#### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)
- **Planned Reporting Period:** 1 or 2
- **Domain 2 - Estimated Maximum Incentive Amount**
  - Year 2: $756,269
  - Year 3: $809,405
  - Year 4: $881,247

#### Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.
- **Planned Reporting Period:** 1 or 2
- **Domain 3 - Estimated Maximum Incentive Amount**
  - Year 2: $809,405
  - Year 3: $881,247

#### Domain 4: Patient Centered Healthcare
- **Patient Satisfaction - HCAHPS**
  - Measurement period for report: Oct. 1 – Sept. 30
  - Planned Reporting Period: 1 or 2
  - Year 2: 1
  - Year 3: 1
  - Year 4: 1
  - Year 5: 1

- **Medication Management**
  - Measurement period for report: Oct. 1 – Sept. 30
  - Planned Reporting Period: 1 or 2
  - Year 2: 1
  - Year 3: 1
  - Year 4: 1
  - Year 5: 1
| Domain 4 - Estimated Maximum Incentive Amount |          | $756,269 | $809,405 | $881,247 |
| Domain 5: Emergency Department |          |          |          |          |
| Planned Reporting Period: 1 or 2 |          | 1 | 1 | 1 |
| Domain 5 - Estimated Maximum Incentive Amount |          | $756,269 | $809,405 | $881,247 |
| **OPTIONAL Domain 6: Children and Adult Core Measures** |          |          |          |          |
| *Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (5 measures)* |          |          |          |          |
| Planned Reporting Period: 1 or 2 |          | 1 | 1 | 1 |
| *Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (8 measures)* |          |          |          |          |
| Planned Reporting Period: 1 or 2 |          | N/A | N/A | N/A |
| Domain 6 - Estimated Maximum Incentive Amount |          |          |          |          |
| **Grand Total Payments Across Category 4** |          | $1,631,034 | $3,781,345 | $4,047,025 | $4,406,235 |

96600
OakBend Medical Center
Performing Provider Name: OakBend Medical Center
Performing Provider TPI #: 127303903

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – OakBend Medical Center (“OakBend”) will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. OakBend plans to implement a Category 2 DSRIP project with the goal of addressing the root causes of potentially preventable admissions. Specifically, this project will provide navigational services to targeted patients who are at high risk of disconnect from institutionalized healthcare. OakBend expects that this project will reduce potentially preventable admissions by making it easier for more patients to receive the primary care they need in appropriate outpatient settings rather than inpatient or emergent settings. OakBend also believes that this project will allow expensive health conditions to be detected and treated early and inexpensively.

- **Valuation Rationale/Justification** – The value OakBend has placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs at OakBend will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. OakBend values this reporting domain at $484,722 over Demonstration Years 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – OakBend will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. OakBend expects that its improvement of access to primary care services through establishing additional primary care providers will allow patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR.

- **Valuation Rationale/Justification** - The value OakBend placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases (e.g., diabetes and congestive heart failure) and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in
conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs at OakBend will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. OakBend values this reporting domain at $484,722 over Demonstration Years 3-5.

**Domain 3: Potentially Preventable Complications (64 measures)**

- **Description** – OakBend will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and OakBend is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. OakBend expects that its expanded provision of primary care and of follow-up care for chronic diseases will reduce the volume of unnecessary utilization of hospital services, thus alleviating one of the problems which can result in unnecessary complications for inpatients. The ongoing quality improvement activities which constitute an essential part of OakBend’s Category 3 projects will also help to ensure that error rates and complications are reduced at all levels of care throughout OakBend.

- **Valuation Rationale/Justification** - The value OakBend placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital’s patients and the hospital’s operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. OakBend values this reporting domain at $335,074 over Demonstration Years 3-5.

**Domain 4: Patient-Centered Healthcare (2 measures)**

- **Description** – OakBend will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient’s willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. OakBend is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital’s providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. OakBend expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with OakBend’s projects to strengthen primary care access in the community and to promote and facilitate management of chronic conditions, because satisfied patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management).
• **Valuation Rationale/Justification** - The value OakBend placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from OakBend and how well OakBend performs its primary care and post-discharge functions. OakBend is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease is costly to patients’ health and to the delivery system, and OakBend believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community. OakBend values this reporting domain at $484,722 over Demonstration Years 3-5.

**Domain 5: Emergency Department (1 measure)**

• **Description** – OakBend will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. This reporting domain ties in with one of the overall aims of the waiver: to reduce inappropriate use of the ED. One cause of extended ED departure times results from an overcrowded ED. OakBend intends to expand access to primary care for patients who currently are unable to access primary care due to factors such as the lack of primary care providers in the community, and to improve follow-up care for discharged patients diagnosed with chronic health conditions, which OakBend expects will reduce the number of inappropriate ED visits and therefore allow for better management of ED processes such as admit decisions.

• **Valuation Rationale/Justification** - The value OakBend placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. OakBend values this reporting domain at $484,722 over Demonstration Years 3-5.
Category 4 Table: The RHP plan shall include the planned semi-annual reporting period, 1 (October 1 – March 31) or 2 (April 1 – September 30) for each domain or measure.
- **DY 2** incentive payments are for submission to HHSC of a status report that describes the system changes the hospital is putting in place to prepare to successfully report Category 4 measures in DYs 3-5.
- **Category 4** reporting shall begin in **DY 3** for Domains 1, 2, 4, 5, and 6 (optional), in **DY 4** for Domain 3, and continue for all Domains through **DY 5**.

### Category 4: Population-Focused Measures
**OakBend Medical Center – TPI: 127303903**

<table>
<thead>
<tr>
<th></th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capability to Report Category 4</strong></td>
<td></td>
<td>Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</td>
<td>Milestone: Status report submitted to HHSC confirming system capability to report Domains 3.</td>
<td></td>
</tr>
<tr>
<td>Estimated Maximum Incentive Amount</td>
<td>$320,070</td>
<td>$149,462</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Domain 1: Potentially Preventable Admissions (PPAs)**

- **Planned Reporting Period:** 1 or 2
  - **Domain 1 - Estimated Maximum Incentive Amount**: $149,462, $161,060, $174,775

**Domain 2: Potentially Preventable Readmissions (30-day readmission rates)**

- **Planned Reporting Period:** 1 or 2
  - **Domain 2 - Estimated Maximum Incentive Amount**: $149,462, $161,060, $174,775

**Domain 3: Potentially Preventable Complications (PPCs)** -- Includes a list of 64 measures identified in the RHP Planning Protocol.

- **Planned Reporting Period:** 1 or 2
  - **Domain 3 - Estimated Maximum Incentive Amount**: $161,060, $174,775

**Domain 4: Patient Centered Healthcare**

**Patient Satisfaction - HCAHPS**

- **Measurement period for report**: Oct. 1 – Sept. 30
  - **Planned Reporting Period:** 1 or 2
    - | Year 2 | Year 3 | Year 4 | Year 5 |
    - | 1 | 1 | 1 | 1 |

**Medication Management**

- **Measurement period for report**: Oct. 1 – Sept. 30
  - **Planned Reporting Period:** 1 or 2
    - | Year 2 | Year 3 | Year 4 | Year 5 |
    - | 1 | 1 | 1 | 1 |
<table>
<thead>
<tr>
<th>Domain 4 - Estimated Maximum Incentive Amount</th>
<th></th>
<th>$149,462</th>
<th>$161,060</th>
<th>$174,775</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td></td>
<td>$149,462</td>
<td>$161,060</td>
<td>$174,775</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>OPTIONAL Domain 6: Children and Adult Core Measures</td>
<td><strong>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (5 measures)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (8 measures)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Domain 6 - Estimated Maximum Incentive Amount</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Total Payments Across Category 4</td>
<td>$318,648</td>
<td>$747,312</td>
<td>$805,300</td>
<td>$873,875</td>
</tr>
</tbody>
</table>
Rice Medical Center
Performing Provider Name: Rice Medical Center (“Rice”)  
Performing Provider TPI #: 212060201

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Rice will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Rice expects that its provision of expanded primary and specialty care services through the Family Practice Obstetrician project, the establishment of the Wallis clinic, the use of telemedicine for specialty consults, the addition of ENT specialty services at Rice, and the expansion of the East Bernard Clinic will reduce the number of PPAs over the life of the Waiver. Additionally, Rice hopes that its project to conduct outreach to patients with chronic diseases and its project to create a Certified Diabetes Teaching Center will enable targeted patients to engage in self-management goals and activities of daily living that are essential to preventing PPAs. Finally, Rice intends for its ImmTrack project to reduce the number of PPAs related to flu and other illnesses that can be prevented through immunizations.

- **Valuation Rationale/Justification** – The value Rice placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in Colorado and Wharton Counties will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. Rice values this reporting domain at $236,577 over Demonstration Years 3-5, requiring local funding of $97,730.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Rice will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Rice expects that its outreach activities will allow chronically ill patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR. With specific regard to diabetic patients, Rice expects its Certified Diabetes Teaching Center to assist diabetic patients in addressing the short- and long-term complications that led to their hospitalizations, and prevent subsequent relapses. Finally, the expanded number and size of clinics in the community will increase the resources available to patients upon discharge from an inpatient stay.
Valuation Rationale/Justification - The value Rice placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs in Colorado County will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Many hospitalizations at Rice can be linked to manageable chronic diseases that Rice intends to address with its project to expand access to primary care. Rice values this reporting domain at $236,577 over Demonstration Years 3-5, requiring local funding of $97,730.

Domain 3: Potentially Preventable Complications (64 measures)

Description – Rice will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and Rice is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Rice expects that its Category 1 project to expand access to primary care will reduce the strain on Rice’s hospital resources (including staff, space, and equipment). Rice also hopes that its ImmTrack project will have a positive impact on PPCs that can be related to duplicative or missed immunizations.

Valuation Rationale/Justification - The value Rice placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital’s patients and the hospital’s operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Rice values this reporting domain at $158,067 over Demonstration Years 3-5, requiring local funding of $65,298.

Domain 4: Patient-Centered Healthcare (2 measures)

Description – Rice will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient’s willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. Rice is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital’s providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. Rice expects improved patient satisfaction in the hospital setting and effective medication management protocols for
inpatients to correlate with Rice’s Category 1 project to expand primary care access, and its projects targeting chronic diseases, because satisfied patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management).

- **Valuation Rationale/Justification** - The value Rice placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Rice and how well Rice performs its function of promoting medication management. Rice is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease in Colorado County is costly to patients’ health and to the delivery system, and Rice believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community. Rice values this reporting domain at $236,577 over Demonstration Years 3-5, requiring local funding of $97,730.

**Domain 5: Emergency Department (1 measure)**

- **Description** – Rice will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. This reporting domain ties in with Rice’s Category 2 project to reduce inefficiencies the ED, because an effect of this project’s successful implementation will be to reduce overall ED treatment, admit, and discharge times. One cause of extended ED departure times is an overcrowded ED, so Rice also intends to expand access to primary care in the community and to provide support to chronically ill patients, which Rice expects will reduce the number of inappropriate ED visits.

- **Valuation Rationale/Justification** - The value Rice placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Rice values this reporting domain at $236,577 over Demonstration Years 3-5, requiring local funding of $97,730.
**Category 4 Table**: The RHP plan shall include the planned semi-annual reporting period, 1 (October 1 – March 31) or 2 (April 1 – September 30) for each domain or measure.

- **DY 2 incentive payments are for submission to HHSC of a status report that describes the system changes the hospital is putting in place to prepare to successfully report Category 4 measures in DYs 3-5.**
- **Category 4 reporting shall begin in DY 3 for Domains 1, 2, 4, 5, and 6 (optional), in DY 4 for Domain 3, and continue for all Domains through DY 5.**

### Category 4: Population-Focused Measures

**Rice Medical Center – TPI: 212060201**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Maximum Incentive Amount</td>
<td>$194,724</td>
<td></td>
<td>$78,509</td>
<td></td>
</tr>
</tbody>
</table>

### Domain 1: Potentially Preventable Admissions (PPAs)

<table>
<thead>
<tr>
<th>Planned Reporting Period: 1 or 2</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1 - Estimated Maximum Incentive Amount</td>
<td>1</td>
<td>$78,509</td>
<td>$78,824</td>
<td>$79,244</td>
</tr>
</tbody>
</table>

### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

<table>
<thead>
<tr>
<th>Planned Reporting Period: 1 or 2</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 2 - Estimated Maximum Incentive Amount</td>
<td>1</td>
<td>$78,509</td>
<td>$78,824</td>
<td>$79,244</td>
</tr>
</tbody>
</table>

### Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.

<table>
<thead>
<tr>
<th>Planned Reporting Period: 1 or 2</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 3 - Estimated Maximum Incentive Amount</td>
<td>1</td>
<td></td>
<td>$78,824</td>
<td>$79,244</td>
</tr>
</tbody>
</table>

### Domain 4: Patient Centered Healthcare

#### Patient Satisfaction - HCAHPS

|--------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|

#### Medication Management

|--------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|

<table>
<thead>
<tr>
<th>Domain 4 - Estimated Maximum Incentive Amount</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$78,509</td>
<td>$78,824</td>
<td>$79,244</td>
<td></td>
</tr>
</tbody>
</table>
## Domain 5: Emergency Department

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td>$78,509</td>
<td>$78,824</td>
<td>$79,244</td>
</tr>
</tbody>
</table>

## OPTIONAL Domain 6: Children and Adult Core Measures

### Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Domain 6 - Estimated Maximum Incentive Amount

| $0 | $0 | $0 |

## Grand Total Payments Across Category 4

| $194,724 | $392,546 | $394,119 | $396,218 |
St. Joseph Medical Center
Category 4: Population-Focused Improvements (Hospitals only)

Title: Required Reporting Domains
Project Identification Number: 181706601
Project Option Reference Number: Domain 1 – Potentially Preventable Admissions (PPAs)
Performing Provider Name / TPI: St. Joseph Medical Center - 181706601

<table>
<thead>
<tr>
<th>PROJECT RELATIONSHIPS TO DOMAIN</th>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.17.1 –</td>
<td>IT-1.18 Follow-Up after</td>
<td>IT-9.2 ED appropriate</td>
</tr>
<tr>
<td></td>
<td>Design, implement,</td>
<td>Hospitalization for Mental</td>
<td>utilization</td>
</tr>
<tr>
<td></td>
<td>and evaluate interventions</td>
<td>Illness – NQF 0576</td>
<td></td>
</tr>
<tr>
<td></td>
<td>to improve care transitions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>from the inpatient setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>for individuals with mental</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>health and/or substance abuse disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.15.1 – Design, implement and evaluate interventions to improve care transitions from the mental health and/or substance abuse disorder- Create a Med/Psych Unit on the campus of St Joseph Medical Center</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Category 4 focuses on reporting six (6) key measure sets designed to gain information and understanding on the health needs of low-income, Medicaid or uninsured patients and their families. St. Joseph Medical Center has selected two Behavioral Health projects (Medical-Psychiatric Unit and Partial Hospitalization Program for Behavioral Health/Substance Abuse) which in turn will facilitate the reduction of unnecessary hospitalizations for those disease conditions which are prevalent in Harris County and the surrounding regions.

In Texas, potentially preventable admissions have been linked to secondary diagnoses of mental illness/substance abuse or in the following medical conditions:

- Congestive Heart Failure (CHF)
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD) – 44.4% of patients admitted to a hospital with this diagnosis had a secondary diagnosis of mental illness/substance abuse;
- Asthma – 37.0% of patients admitted to a hospital with this diagnosis had a secondary diagnosis of mental illness/substance abuse;
• Bacterial Pneumonia – 32.5% of patients admitted to a hospital with this diagnosis had a secondary diagnosis of mental illness/substance abuse (Texas Health and Human Services Commission, 2012).

• Influenza Immunization

St. Joseph Medical Center recognizes that there is a high prevalence of co-occurring mental health and medical issues in the United States. Currently patients with medical illnesses develop depression 10-14% of the time. The rate increases as the severity of illness increases. In many cases, the diagnosis of depression is missed 50% of the time in primary care settings. Likewise, people with a mental illness experience greater distress, an increase in impaired functioning and less ability to follow medical regimens, thus hindering the treatment of any other medical conditions. Taking into account the lack of beds in Harris County and the surrounding areas, St. Joseph Medical Center has chosen to open new services designed to provide behavioral health patients with better wrap around services. The Medical-Psychiatric Unit will provide the right care in the right setting. This unit will care for those patients who previously did not receive needed behavioral health care because their medical diagnosis became a priority. It can also care for patients who did not have their medical needs addressed due to their overriding psychiatric disease. The Partial Hospitalization Program will provide behavioral health and/or substance abuse patients with the support and skills to care for themselves in the residential setting.

The medical psychiatry program will effect this domain by ensuring that those patients who are more medically complex are not admitted to a pure medical unit or a pure psychiatry unit. These admissions will instead admit to a more appropriate inpatient setting where both of these issues are addressed. The second proposal, expansion of outpatient services will ensure that those patients who do not require hospitalization are given better wrap-around services and thus avoid re-admission to the inpatient psychiatry unit.

Valuation
The valuation of the Medical-Psychiatric Unit and the Partial Hospitalization Program takes into account the degree to which the projects accomplish community needs, the population served (both number of people served and complexity of patient needs), and investment required to implement the projects. The projects seek to reduce the cost of delivering inpatient care in the community by addressing quality of care in a cost efficient model and attempting to reduce unnecessary admissions through better health outcomes for patients. It is the expectation that the opening of a 12 bed Medical-Psychiatric Unit to treat patients with co-occurring medical and psychiatric needs and the Partial Hospitalization Program that will teach patients the skills to care for themselves in the residential setting and will decrease the number of admissions to the hospital.
A: **Category 4: Population-Focused Improvements**

Title: Required Reporting Domains  
Project Identification Number: 181706601  
Project Option Reference Number: Domain 2 – Potentially Preventable Readmissions (PPRs)  
Performing Provider Name / TPI: St. Joseph Medical Center - 181706601

### PROJECT RELATIONSHIPS TO DOMAIN

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.17.1 – Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders</td>
<td>IT-1.18 Follow-Up after Hospitalization for Mental Illness – NQF 0576</td>
</tr>
<tr>
<td></td>
<td>2.15.1 – Design, implement and evaluate interventions to improve care transitions from the mental health and/or substance abuse disorder - Create a Med/Psych Unit on the campus of St Joseph Medical Center ns</td>
<td>IT-9.2 ED appropriate utilization</td>
</tr>
</tbody>
</table>

Domain 1 description for “Potentially Preventable Admissions” applies to Domain 2 “Potentially Preventable Readmissions”. Currently, there are two medical-psychiatric units in Houston. There is the unit at Ben Taub and another unit at Memorial Southwest. According to statements both by their own staff and from referrers within the community, these units stay consistently full and it is virtually impossible to get a patient from another facility to either one of these units.

St. Joseph Medical Center has selected two Behavioral Health projects (Medical-Psychiatric Unit and Partial Hospitalization Program for Behavioral Health/Substance Abuse) with the underserved population in mind. Both of these programs will facilitate the reduction of unplanned readmissions to the Hospital within 30 days of discharge for those disease conditions which are identified.

In Texas, potentially preventable readmissions within 30 days have been linked to secondary diagnoses of mental illness/substance abuse or in the following medical conditions:

- Congestive Heart Failure (CHF)
- Diabetes
St. Joseph Medical Center recognizes that there is a high prevalence of co-occurring mental health and medical issues in the United States. Currently patients with medical illnesses develop depression 10-14% of the time. The rate increases as the severity of illness increases. In many cases, the diagnosis of depression is missed 50% of the time in primary care settings. Likewise, people with a mental illness experience greater distress, an increase in impaired functioning and less ability to follow medical regimens, thus readmissions to the Hospital for reassessment of a continuing condition or for the treatment of other medical conditions occurs more frequently. Taking into account the lack of beds in Harris County and the surrounding areas, St. Joseph Medical Center has chosen to open new services designed to provide behavioral health patients with better wrap around services. The Medical-Psychiatric Unit will provide the right care in the right setting for the those patients who previously did not receive needed behavioral health care because their medical diagnosis became a priority. It also can care for those patients who did not have their medical needs addressed due to their overriding psychiatric disease. The Partial Hospitalization Program will provide behavioral health and/or substance abuse patients with the support and skills to care for themselves in the residential setting. The Program focuses on medication compliance, living situation stability, therapy and aftercare needs. It is expected that these two new programs working together will reduce the recidivism and/or readmissions to the Hospital.

The medical psychiatry program will effect this domain by ensuring that those patients who are more medically complex are treated in the right setting from the onset of their care. By treating those patients in the right setting, we anticipate a reduction in re-admissions. The second proposal, expansion of outpatient services will ensure that those patients who do not require hospitalization are given better wrap-around services and thus avoid re-admission to the inpatient psychiatry unit.

Valuation
The valuation of the Medical-Psychiatric Unit and the Partial Hospitalization Program takes into account the degree to which the projects accomplish community needs, the population served (both number of people served and complexity of patient needs), and investment required to implement the projects. The projects seek to reduce the cost of delivering inpatient care in the community by addressing quality of care in a cost efficient model and attempting to reduce unplanned readmissions through better health outcomes for patients. It is the expectation that the opening of a 12 bed Medical-Psychiatric Unit to treat patients with co-occurring medical and psychiatric needs and the Partial Hospitalization Program that will teach patients the skills to care for themselves in the residential setting will decrease the number of readmissions to
the Hospital. It is foreseen that any reduction in readmissions in any population will result in cost savings and appropriate utilization of resources. The baseline goal will be determined by opportunity analysis and needs assessment results.

*St. Joseph Medical Center will not submit data related to Pediatric Asthma as we do not have a Pediatric Unit. Pediatric patients requiring admission are transferred to one of the Pediatric Hospitals located in the Houston area.

A: **Category 4: Population-Focused Improvements**

Title: Required Reporting Domains
Project Identification Number: 181706601
Project Option Reference Number: Domain 3 – Potentially Preventable Complications (PPCs)
Performing Provider Name / TPI: St. Joseph Medical Center – 181706601

<table>
<thead>
<tr>
<th>PROJECT RELATIONSHIPS TO DOMAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1</strong></td>
</tr>
<tr>
<td>2.17.1 – Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders</td>
</tr>
<tr>
<td>2.15.1 – Design, implement and evaluate interventions to improve care transitions from the mental health and/or substance abuse disorder - Create a Med/Psych Unit on the campus of St Joseph Medical Center</td>
</tr>
</tbody>
</table>

Congestive heart failure, chronic obstructive pulmonary disease, diabetes, stroke, behavioral diseases, etc. are chronic diseases. Individuals must learn self-management skills and make lifestyle changes to effectively manage these illnesses to avoid or delay complications. For these reasons self-management education and medical management are the cornerstone of treatment for people with chronic diseases. Enhancing the chronic disease inpatient programs and developing new outpatient programs designed to help individuals manage their illness will result in improved patient outcomes for this population.

In addition, the implementation of *Lean* methodology will be instrumental in the improvement of patient care and safety, the reduction of hospital-acquired conditions, and increased staff efficiency through the promotion of evidence based medical and nursing practice at the facility.
Domain 3 focuses on multiple quality outcome measures and specifically on Sepsis Mortality (#35 on PPC list) as a potentially preventable condition / healthcare acquired condition. Research on sepsis reveals that there is a wide variation in healthcare practice in different geographical areas which have not kept in pace with the evolving science of healthcare to ensure evidence based practice. Treatment for sepsis is an example of how variation in healthcare can be reduced. This, in turn, will have an effect on mortality and the number of patients developing infections and/or potentially preventable complications. St. Joseph Medical Center aspires to reduce the sepsis mortality rate by utilizing the nationally recommended “Bundle” concept included in the Surviving Sepsis Campaign which is a global initiative.

Valuation

Based on HealthGrades data regarding the average cost of treating a sepsis patient and the average length of stay for a sepsis patient at St. Joseph Medical Center, it is projected that reducing the number of complications in the aforementioned diagnoses will facilitate improvement and can potentially save $4,012,000 over a five (5) year period.

A: Category 4: Population-Focused Improvements

Title: Required Reporting Domains
Project Identification Number: 181706601
Project Option Reference Number: Domain 4 – Patient Centered Healthcare
Performing Provider Name / TPI: St. Joseph Medical Center – 181706601

<table>
<thead>
<tr>
<th>PROJECT RELATIONSHIPS TO DOMAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1</strong></td>
</tr>
<tr>
<td>2.17.1 – Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders</td>
</tr>
<tr>
<td>2.15.1 – Design, implement and evaluate interventions to improve care transitions from the mental health and/or substance abuse disorder- Create a</td>
</tr>
</tbody>
</table>
This project has been designed to improve patient care and patient satisfaction through the provision of adequate services, adequate hours, adequate resources, and optimal healthcare services reflective of evidence based practice standards. These factors will be monitored through use of the HCAHPS tool for the inpatient programs. HCAHPS has been implemented on every medical-surgical floor and St Joseph’s Hospital clearly recognizes the need to ensure that the inpatient program will have HCAHPS measures installed for the medical – psychiatry program. HCAHPS does not currently have a measurement tool for outpatient monitoring of patient satisfaction. We will develop and monitor patient satisfaction through an internal tool developed at another facility within the hospital system. This tool was specifically designed to monitor patient satisfaction on an outpatient basis. Through sustained utilization of the HCAHPS patient satisfaction tools and reports during this project’s subsequent years, St. Joseph Medical Center will monitor the results and continue to identify opportunities for improvement. Appropriate corrective actions will be developed for the provision of appropriate patient centered care, whereby patient satisfaction will be maintained and improved.

A secondary focus of this project is appropriate Medication Management. The Lean methodology will facilitate the redesign and implementation of an improved patient centered medication management program limited to the inpatient setting. This program will promote patient safety through the appropriate prescribing, dispensing, administering, and, in particular, using of prescribed medications upon discharge from the hospital.

**Valuation**

Patient satisfaction is a major determinant of return “business” for a healthcare facility and is also a factor which influences reimbursement for services rendered. Applying the efficiency, effectiveness, and safety aspects of the Lean methodology to the medication management process will eliminate numerous non-value steps in the current process which in turn will promote cost savings.

**A: Category 4: Population-Focused Improvements**

Title: Required Reporting Domains

Project Identification Number: 181706601

Project Option Reference Number: Domain 5 – Emergency Department (ED)

Performing Provider Name / TPI: St. Joseph Medical Center – 181706601

<table>
<thead>
<tr>
<th>PROJECT RELATIONSHIPS TO DOMAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
</tr>
<tr>
<td>2.17.1 – Design, implement,</td>
</tr>
<tr>
<td>and evaluate interventions</td>
</tr>
</tbody>
</table>
The purpose of expanding primary care services includes the goal of reducing the number of potentially avoidable visits to the St. Joseph Medical Center’s Emergency Department and provide the right care in the right setting. People with depression or other behavioral disease experience greater distress, an increase in impaired functioning and less ability to follow medical regimens, thus hindering the treatment of any other medical conditions. In addition, depression occurs in 10 to 27 percent of stroke survivors and usually lasts about one year. It occurs in 40-65% of patients who have a heart attack and in 25% of cancer patients. People with bipolar disorder are also at higher risk for thyroid disease, migraine headaches, heart disease, diabetes, obesity, and other physical illnesses.

Baseline data indicates that these diagnoses are among the most frequently recorded non-emergent ED visits which can actually be cared for in the primary care system. When these same patients arrive in our ED, they will be screened for a secondary diagnosis of mental health illness and, if this diagnosis is potentially present, the patient will be given diagnosis-specific education and then be directed to the most appropriate primary or inpatient care setting that provides mental health resources for follow up. This may be our Medical-Psychiatric Unit, our Partial Hospitalization Program for outpatient treatment or to Intake for inpatient behavioral health care. This realignment will result in better health outcomes, patient satisfaction, appropriate ED utilization, and reduced cost of services.

The medical psychiatry program will effect this domain by ensuring that there is a care setting for the medical/psychiatry patient. Having this program should result in decreased times that patients languish in the ED environment. The second proposal, expansion of outpatient services will ensure that those patients who do not require hospitalization are given better wrap-around services and thus avoid re-admission to the inpatient psychiatry unit and actually reduce the number that simply “show up or walk into” to the ED for care.
Valuation

It is projected that the number of patients screened for mental health illness in the ED will increase by 2-3% over the baseline number. A primary goal is to measure the results of strategies identified. It is anticipated that education of the frequent ED patients will assist them in identifying and accessing those healthcare provider services most appropriate for their care in the future; this, in turn, will promote cost savings and proper provider utilization. In addition, it will promote more timely treatment of those patients presenting to the ED with more serious medical conditions. Time monitoring of when these patients arrive to the ED to when they are evaluated to when their disposition/decision to admit or not admit will be tightly monitored in a log that displays this information.

A: Category 4: Population-Focused Improvements

Title: Required Reporting Domains
Project Identification Number: 181706601
Project Option Reference Number: Domain 6 – Children and Adult Core Measures (Optional)
Performing Provider Name / TPI: St. Joseph Medical Center – 181706601

<table>
<thead>
<tr>
<th>PROJECT RELATIONSHIPS TO DOMAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

It is the intent of St. Joseph Medical Center to report on RD-6. Optional Domain: Initial Core Set of Health Care Quality Measures which will require the collection and submission of data on hospital services provided for children in the Medicaid and CHIP programs, as well as Medicaid eligible adults. In addition, data analysis will be performed with resultant recommendations
communicated for corrective actions to be taken related to those measures which indicate opportunities for improvement.

Valuation
The significant values of this reporting domain will be healthcare cost savings, appropriate healthcare utilization, improved patient outcomes, and improved patient satisfaction.

St. Joseph Medical Center will not submit data related to Pediatric Intensive Care Unit as we do not have a Pediatric Care Unit. Pediatric patients requiring admission to an ICU are transferred to one of the Pediatric Hospitals located in the Houston area.

References

### Category 4: Population-Focused Measures

**St. Joseph Medical Center - 181706601**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone:</strong> Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Maximum Incentive Amount</td>
<td>$310,000</td>
<td>$ 192,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Domain 1: Potentially Preventable Admissions (PPAs)

Planned Reporting Period: 1 or 2 | 2 | 2 | 2

- **Domain 1 - Estimated Maximum Incentive Amount**
  - Year 2: $192,000
  - Year 3: $214,000
  - Year 4: $211,000

#### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

Planned Reporting Period: 1 or 2 | 2 | 2 | 2

- **Domain 2 - Estimated Maximum Incentive Amount**
  - Year 2: $192,000
  - Year 3: $214,000
  - Year 4: $211,000

#### Domain 3: Potentially Preventable Complications (PPCs)

Includes a list of 64 measures identified in the RHP Planning Protocol.

Planned Reporting Period: 1 or 2 | 2 | 2

- **Domain 3 - Estimated Maximum Incentive Amount**
  - Year 2: $214,000
  - Year 3: $211,000

#### Domain 4: Patient Centered Healthcare

**Patient Satisfaction – HCAHPS**


- **Planned Reporting Period: 1 or 2**
  - Year 2: 2
  - Year 3: 2
  - Year 4: 2

**Medication Management**


- **Planned Reporting Period: 1 or 2**
  - Year 2: 2
  - Year 3: 2
  - Year 4: 2

- **Domain 4 - Estimated Maximum Incentive Amount**
  - Year 2: $192,000
  - Year 3: $214,000
  - Year 4: $211,000
### Domain 5: Emergency Department

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Domain 5 - Estimated Maximum Incentive Amount

|                          | $ 192,000 | $ 214,000 | $ 211,000 |

### OPTIONAL Domain 6: Children and Adult Core Measures

#### Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Domain 6 - Estimated Maximum Incentive Amount

|                          | $ 192,000 | $ 214,000 | $ 211,000 |

### Grand Total Payments Across Category 4

|                          | $ 310,000 | $ 1,152,000 | $ 1,284,000 | $ 1,266,000 |
St. Luke's Episcopal Hospital
Category 4 Population-Focused Improvements

Performing Provider Name: St. Luke’s Episcopal Hospital
Performing Provider TPI #: 127300503
Pass I project - 2.12.1- Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions: Transitional Care for Chronic Disease
Pass 2 project – 2.2.2 –Apply evidence based care management model to patients identified as having high-risk health care needs – Identification and Treatment of Patients with Hepatitis C.

The domains would be applicable to both projects.

Domain 1: Potentially Preventable Admissions (8 measures)
  • Description Most measures require the number of residents age 18 or older living in the RHP counties to determine the denominator. This data would need to be provided by the state. Behavioral health and substance abuse admission rate would not be measurable since our facility does not provide psychiatric or substance abuse services.
  • Valuation - $507,703
  • Rationale/Justification - One of the goals of the project, as well as the Region’s goals, is to increase reliance on primary care settings and to create a bridge to community based providers of primary care. Stable, ongoing primary care relationships are vital to reducing year-over-year readmission rates. We believe our continuum of care once developed will reduce year-over-year admissions by 30% of those patients enrolled and successfully placed in a primary care home.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)
  • Description We will be able to report data for all areas in this domain with the exception of behavioral health and substance abuse admission 30-day readmission rate. Since we do not provide psychiatric or substance abuse services, we would not be able to report this data.
  • Valuation – $507,703
  • Rationale/Justification - The impact of the project can be tracked through readmissions. The goal would be to reduce readmissions. One of the most powerful interventions to reduce 30-day readmissions in the CHF population is rapid access to a care provider within 7 days of hospital discharge. The Transitional Care Clinic will meet this need and therefore achieve a reduction in 30-day readmissions of 30%, consistent with current literature supporting this intervention.

Domain 3: Potentially Preventable Complications (64 measures)
  • Description We will be able to report data for all areas in this domain.
  • Valuation - $351,064
  • Rationale/Justification – The value placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Complications of care are often the result of unplanned deterioration. The ability to rapidly intervene and within the context of a care continuum, enhanced patient activation will occur.
**Domain 4:** Patient-Centered Healthcare (2 measures)
- **Description** We will be able to report data for all areas in this domain.
- **Valuation** - $507,703
- **Rationale/Justification** - The value placed on this domain is based upon the value the hospital attributes to understanding how well is it serving its patients and the health/financial impacts of patient satisfaction in improving self-management, patient follow up and perceived quality of life and care. Transition to stable primary is one goal of this program. The development of relationships with CBO’s will facilitate and serve as a connector.

**Domain 5:** Emergency Department (1 measure)
- **Description** We will be able to report data for all areas in this domain.
- **Valuation** - $507,706
- **Rationale/Justification** - More engaged patients with facilitated access to primary care should reduce unnecessary ED visits. Though not a specific goal of this project, this is one of the metrics easily monitored for those individuals who become enrolled in the program.

**Optional Domain 6:** Children and Adult Core Measures (8 measures) **N/A**
- **Description** We have opted out of reporting for this domain.
- **Valuation**
- **Rationale/Justification**
## Category 4: Population-Focused Measures

**St. Luke's Episcopal Hospital/ TPI 127300503**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</td>
<td></td>
<td>$292,404</td>
<td>$156,639</td>
<td></td>
</tr>
<tr>
<td>Estimated Maximum Incentive Amount</td>
<td>$292,404</td>
<td>$156,639</td>
<td>$168,261</td>
<td>$182,803</td>
</tr>
</tbody>
</table>

### Domain 1: Potentially Preventable Admissions (PPAs)

- **Planned Reporting Period:** 1 or 2
- **Domain 1 - Estimated Maximum Incentive Amount:**
  - Year 2: $292,404
  - Year 3: $156,639
  - Year 4: $168,261
  - Year 5: $182,803

### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

- **Planned Reporting Period:** 1 or 2
- **Domain 2 - Estimated Maximum Incentive Amount:**
  - Year 2: $292,404
  - Year 3: $156,639
  - Year 4: $168,261
  - Year 5: $182,803

### Domain 3: Potentially Preventable Complications (PPCs)

Includes a list of 64 measures identified in the RHP Planning Protocol.

- **Planned Reporting Period:** 1 or 2
- **Domain 3 - Estimated Maximum Incentive Amount:**
  - Year 2: $292,404
  - Year 3: $156,639
  - Year 4: $168,261
  - Year 5: $182,803

### Domain 4: Patient Centered Healthcare

**Patient Satisfaction - HCAHPS**
### Category 4: Population-Focused Measures

**St. Luke's Episcopal Hospital/ TPI 127300503**

<table>
<thead>
<tr>
<th>Year</th>
<th>Measurement period for report</th>
<th>Planned Reporting Period: 1 or 2</th>
<th>Domain 4 - Estimated Maximum Incentive Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 2</strong> (10/1/2012 – 9/30/2013)</td>
<td>10/1/13-9/30/14</td>
<td>2</td>
<td>$156,639</td>
</tr>
<tr>
<td><strong>Year 3</strong> (10/1/2013 – 9/30/2014)</td>
<td>10/1/14-9/30/15</td>
<td>2</td>
<td>$168,261</td>
</tr>
<tr>
<td><strong>Year 4</strong> (10/1/2014 – 9/30/2015)</td>
<td>10/1/15-9/30/16</td>
<td>2</td>
<td>$182,803</td>
</tr>
<tr>
<td><strong>Year 5</strong> (10/1/2015 – 9/30/2016)</td>
<td>10/1/16-9/30/17</td>
<td>2</td>
<td>$182,804</td>
</tr>
</tbody>
</table>

### Medication Management

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>Planned Reporting Period: 1 or 2</th>
<th>Domain 4 - Estimated Maximum Incentive Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/13-9/30/14</td>
<td>2</td>
<td>$156,640</td>
</tr>
<tr>
<td>10/1/14-9/30/15</td>
<td>2</td>
<td>$168,262</td>
</tr>
<tr>
<td>10/1/15-9/30/16</td>
<td>2</td>
<td>$182,804</td>
</tr>
</tbody>
</table>

### Domain 5: Emergency Department

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>Planned Reporting Period: 1 or 2</th>
<th>Domain 5 - Estimated Maximum Incentive Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/13-9/30/14</td>
<td>2</td>
<td>$156,640</td>
</tr>
<tr>
<td>10/1/14-9/30/15</td>
<td>2</td>
<td>$168,262</td>
</tr>
<tr>
<td>10/1/15-9/30/16</td>
<td>2</td>
<td>$182,804</td>
</tr>
</tbody>
</table>

### OPTIONAL Domain 6: Children and Adult Core Measures

<table>
<thead>
<tr>
<th>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)</th>
<th>Planned Reporting Period: 1 or 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Measurement period for report</td>
<td>n/a</td>
</tr>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>n/a</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)</th>
<th>Planned Reporting Period: 1 or 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Measurement period for report</td>
<td>n/a</td>
</tr>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>n/a</td>
</tr>
<tr>
<td>Category 4: Population-Focused Measures</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>St. Luke's Episcopal Hospital/ TPI 127300503</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain 6 - Estimated Maximum Incentive Amount</th>
<th>Year 2 (10/1/2012 – 9/30/2013)</th>
<th>Year 3 (10/1/2013 – 9/30/2014)</th>
<th>Year 4 (10/1/2014 – 9/30/2015)</th>
<th>Year 5 (10/1/2015 – 9/30/2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Total Payments Across Category 4</td>
<td>$ 292,404</td>
<td>$ 783,196</td>
<td>$ 841,306</td>
<td>$ 914,016</td>
</tr>
</tbody>
</table>
Texas Children's Hospital
Performing Provider involved with Category 4: Texas Children’s Hospital/139135109

- Domain 1: Potentially Preventable Admissions (8 measures)
- Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)
- Domain 3: Potentially Preventable Complications (64 measures)
- Domain 4: Patient-Centered Healthcare (2 measures)
- Domain 5: Emergency Department (1 measure)
- Optional Domain 6: Children and Adult Core Measures (8 measures)

Domain Descriptions RD1: Potentially Preventable Admissions:
RD1.1, 1.2, 1.4, 1.5 and 1.7 are not applicable to the patient population we serve when using the denominator (Patients over age 18 years old acute care facilities) the the number of admissions at a pediatric hospital 18 years or older is relatively small and these patients tend to be a much sicker population (for example patients suffering from Cystic Fibrosis, Neurological disorders, cardiac anomalies or other). Other acute care hospitals having to report PPRs with an adult population will have a mix of healthy and sick adults in this domain.

RD1.3 Behavior Health and Substance Abuse Admission Rate- As a core pediatric principle in preventative medicine and for any patient accessing care through the Pavilion for Women early recognition of abuse patterns is critical for better health outcomes. The expansion of access allowed for through our Category 1 and 2 projects provides us with the opportunity to diagnose our patient population earlier to mitigate behavioral or substance abuse issues.

RD1.6 Pediatric Asthma- Transitions of care for any chronic disease population such as those we are working to expand access for in our Category 1 and 2 projects, would benefit from a measure such as emergency center utilization for asthma care. Our anticipated result is that we will see a decrease in this utilization as we increase correct asthma plan implementation.

RD1.8 Influenza Immunization- Texas Children’s has a process in place to remind all patients the need to get an influenza immunization. Additionally, we provide free vaccines to all parents of in our inpatient population. We will continue to monitor influenza vaccinations to ensure our high risk populations are protected.

Domain Descriptions: Potentially Preventable Readmissions:
RD2.1, 2.2, 2.3, 2.4 and 2.5 are not applicable to the patient population we serve, when using the denominator (Patients over age 18 years old acute care facilities) the the number of admissions at a pediatric hospital 18 years or older is relatively small and these patients tend to be a much sicker population (for example, patients suffering from Cystic Fibrosis, Neurological disorders, cardiac anomalies or other). Other acute care hospitals having to report PPRs with an adult population will have a mix of healthy and sick adults in this domain ratio. Should Texas Children’s Hospital be required to report on these domains, we request that we work with HHSC and CMS to create a measure that is relevant to the pediatric and young adult population for these PPR categories.

RD2.6 Pediatric Asthma is a high priority of Texas Children’s because we see such a large, high risk population of children impacted by this condition. We expect to have a reduction in our 30
day readmission rate, specifically, those seen in our Category 1 and 2 expansion projects (e.g. pulmonology, allergy and immunology). Our expansion to subspecialty care will help drive patients to the right level of care at the right time.

RD2.7- When using the denominator (Patients over age 18 years old acute care facilities) the the number of admissions at a pediatric hospital 18 years or older is relatively small and these patients tend to be a much sicker population (for example, patients suffering from Cystic Fibrosis, Neurological disorders, cardiac anamolies or other). Other acute care hospitals having to report PPRs with an adult population will have a mix of healthy and sick adults in this domain ratio.

Domain Descriptions RD3: Potentially Preventable Complications:
Currently we are taking our clinical process models and populating them into our Enterprise Data Warehouse (EDW) to better understand and identify gaps in care. We expect that increasing the number of people who have correct access to care will improve the quality of care provided. Our clinical system integration allows us to perform rapid cycle process improvement initiatives specific to our high risk patients. These PDSAs allow us to more efficiently and effectively improve care delivery and ultimately outcomes and create or achieve high quality care standards.

A multi-year contract by CMS was awarded to the Ohio Children’s Hospitals’ Solutions for Patient Safety (OCHSPS), a non-profit organization comprised of the eight children’s hospitals in Ohio. Texas Children’s Hospital, is one of 26 children’s hospitals working with OCHSPS as part of its Partnership for Patients initiative – a priority project designed to reduce hospital inpatient harm by 40% and readmissions by 20% over a 3 year period.

Domain Descriptions RD4: Patient Satisfaction
RD4.1 HCAHPS is not the patient satisfaction tool or survey we use to measure care from doctors, care from nurses and the hospital environment while a patient is in admitted to discharge. We use Press Ganey survey tools and will certainly report these measures, using this valid measuring tool, and disseminate those findings to both internal and external stakeholders.

RD4.2 Medication Management- This is a specific target of our ongoing process improvement initiative using our electronic medical record to identify medications for all inpatient populations that we serve including all subspecialty populations needing to be transferred to reduce medication errors and have accurate reconciliation.

Domain Descriptions RD5: Emergency Department: We are currently initiating the process of measuring departure to ED to time of admission. We hope to demonstrate stronger links between data management centers (Epic and Enterprise Data Warehouse, Disease and medication registries) and call centers to improve patient transfers and reduce diversions. It is our hope this will lead to a reduction in time wasted when a patient is transferred in or out of our facility due to lack of clinical information to provide the appropriate level of care.

A multi-year contract by CMS was awarded to the Ohio Children’s Hospitals’ Solutions for Patient Safety (OCHSPS), a non-profit organization comprised of the eight children’s hospitals in Ohio. Texas Children’s Hospital, is one of 26 children’s hospitals working with OCHSPS as part
of its *Partnership for Patients* initiative – a priority project designed to reduce hospital inpatient harm by 40% and readmissions by 20% over a 3 year period.

OCHSPS is the only pediatric-focused effort in the country. OCHSPS will assist network hospitals in developing a measurement strategy, sharing data, applying High Reliability Organization theory, and using Quality Improvement Science to affect significant reduction in patient harm. Participating children’s hospitals will focus on the following areas of harm:

- Adverse drug events (ADE)
- Catheter-associated urinary tract infections (CAUTI)
- Central line-associated blood stream infections (CLABSI)
- Injuries from falls and immobility
- Pressure ulcers
- Surgical site infections
- Ventilator-associated pneumonia (VAP)
- Preventable readmissions
- Obstetrical adverse events
- Venous thromboembolism
- Serious Safety Events (SSE)

This federally funded collaborative will have training opportunities in leadership methods, error prevention behavior best practices, cause analysis, etc. Texas Children’s Hospital would like to leverage this training and spread this knowledge to our Region 3 stakeholders to improve their quality efforts, improve care and decrease patient harm.

Should Texas Children’s Hospital be required to report on these domains, we request that we work with HHSC and CMS to create a measure that is relevant to the pediatric and young adult population for these PPR categories.

**Domain Valuation:** All of our project’s values are based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.\(^1\) Studies show the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.\(^3\) Our valuation also includes an increase in the patient’s quality of life. We are using a conservative Quality Adjusted Life Year (“QALY”) per year and a percentage of that QALY for the pediatric population.\(^2\) The QALY is used as a one-time improvement in the quality of life, even though we know the patient’s quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. 5-10% of

\(^1\) Regional Healthcare Partnership Plan, 2802 Region 3.
the total valuation for each project we allocated as the value of reporting the category 4 quality metrics.

Texas Children’s Hospital, located in Houston, is the largest free standing children’s hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children’s is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children’s supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.
## Category 4: Population-Focused Measures

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Maximum Incentive Amount</td>
<td>$1,249,395</td>
<td>$482,737</td>
</tr>
</tbody>
</table>

### Domain 1: Potentially Preventable Admissions (PPAs)

Planned Reporting Period: 1 or 2  

<table>
<thead>
<tr>
<th>Year</th>
<th>RP1(October 1 - March 31)</th>
<th>RP1(October 1 - March 31)</th>
<th>RP1(October 1 - March 31)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>$482,737</td>
<td>$516,417</td>
<td>$561,322</td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

Planned Reporting Period: 1 or 2  

<table>
<thead>
<tr>
<th>Year</th>
<th>RP1(October 1 - March 31)</th>
<th>RP1(October 1 - March 31)</th>
<th>RP1(October 1 - March 31)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>$482,737</td>
<td>$516,417</td>
<td>$561,322</td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Domain 3: Potentially Preventable Complications (PPCs)

Includes a list of 64 measures identified in the RHP Planning Protocol.

<table>
<thead>
<tr>
<th>Year</th>
<th>RP1(October 1 - March 31)</th>
<th>RP1(October 1 - March 31)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 (10/1/2012 – 9/30/2013)</td>
<td>$516,417</td>
<td>$561,322</td>
</tr>
<tr>
<td>Year 3 (10/1/2013 – 9/30/2014)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 4 (10/1/2014 – 9/30/2015)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 5 (10/1/2015 – 9/30/2016)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Domain 4: Patient Centered Healthcare

*Patient Satisfaction - HCAHPS - Texas Children's Hospital is requesting to use Press Ganey as its valid patient Satisfaction Survey Tool*
<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>End of fiscal year (9/30/14)</th>
<th>End of fiscal year (9/30/15)</th>
<th>End of fiscal year (9/30/16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>RP1(October 1-March 31)</td>
<td>RP1(October 1-March 31)</td>
<td>RP1(October 1-March 31)</td>
</tr>
</tbody>
</table>

### Medication Management

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>End of fiscal year (9/30/14)</th>
<th>End of fiscal year (9/30/15)</th>
<th>End of fiscal year (9/30/16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>RP1(October 1-March 31)</td>
<td>RP1(October 1-March 31)</td>
<td>RP1(October 1-March 31)</td>
</tr>
</tbody>
</table>

| Domain 4 - Estimated Maximum Incentive Amount | $ 482,737 | $ 516,417 | $ 561,322 |

### Domain 5: Emergency Department

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>End of fiscal year (9/30/14)</th>
<th>End of fiscal year (9/30/15)</th>
<th>End of fiscal year (9/30/16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>RP1(October 1-March 31)</td>
<td>RP1(October 1-March 31)</td>
<td>RP1(October 1-March 31)</td>
</tr>
</tbody>
</table>

| Domain 5 - Estimated Maximum Incentive Amount | $ 482,737 | $ 516,416 | $ 561,322 |

### OPTIONAL Domain 6: Children and Adult Core Measures

**Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)**

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>End of fiscal year (9/30/14)</th>
<th>End of fiscal year (9/30/15)</th>
<th>End of fiscal year (9/30/16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>RP1(October 1-March 31)</td>
<td>RP1(October 1-March 31)</td>
<td>RP1(October 1-March 31)</td>
</tr>
</tbody>
</table>

| Domain 6 - Estimated Maximum Incentive Amount | $ 482,738 | $ 516,437 | $ 565,323 |

### Grand Total Payments Across Category 4

| $ 1,249,395 | $ 2,896,423 | $ 3,098,499 | $ 3,367,934 |
The Methodist Hospital
Patient Data and Quality Reporting: Domains 1 - 5

The Methodist Hospital System (Methodist) has been proactive with regard to federal quality and data reporting requirements. Methodist also currently submits administrative, coded, de-identified data to Texas Health Care Information Collection (THCIC). Once HHSC determines the nature of the data to be reported and the technical specification for reporting, Methodist will develop the appropriate data reporting for Category 4 Domains 1 through 5 and respective measures.

Domain 1, 2, and 3 are based on 3M’s APR-DRGs. Methodist is in the process of implementing MIDAS, a software system that is a 3M partner and utilizes its reporting methodology. MIDAS is a staged implementation which is expected to be in place in 2Q 2013. The system covers Inpatient, Outpatient and Emergency Department patient visit details which are chained encounters.

Domain 4 contains two components: a) Patient-centered health care or patient satisfaction data and b) Medicaid Management. These are currently addressed by two separate reporting systems. Patient satisfaction measures are managed by Press Ganey, which utilizes a survey tool that includes the HCAHPS standard questions. The data is reported to CMS for use in Hospital Compare. Medication management is a functionality of MethOD, our electronic medical record (EMR). The EMR contains the following: home medication list, inpatient medication orders, home to inpatient reconciliation, patient transfer medication reconciliation, medication administration, patient refusal of medication administration, and discharge medication documentation. HHSC currently receives reports from providers in XML formats. Methodist has the capability to provide reports in XML. Once HHSC determines the specific data to be collected and reported, Methodist will evaluate the data capture reporting capability.

Domain 5 relates to Emergency Department admit to departure length of time. HHSC will need to determine whether the approach to this is a core measure approach or a patient management approach. In the event that HHSC seeks to capture core measurement information the MIDAS system discussed above would be expected to capture that information. If the data sought is strictly patient management aimed at arrival date/time and date/time of patient disposition then an ED management system, MedHost, could be utilized for the data collection and reporting.

Category 4 Valuation: Methodist will utilize the 10% valuation for Domains 1 – 5 with an equal spread between domains and measures.

Domain Descriptions: A description of how Category 4 measures relate to the project/outcomes.

Because the DSRP project submitted relates to Care Coordination for Behavioral Medicine patients seen in the Emergency Department, the following Category 4 Domains are specific to the project which Methodist will design and implement. Data will be collected, analyzed and interventions developed for care coordination to reduce admissions, readmissions, patient satisfaction, medication management, complications, and emergency department patient management.
RD-1. Potentially Preventable Admissions

3. Behavioral Health and Substance Abuse Admission rate (based on other selected PPA primary diagnoses)

RD-2. 30-day Readmissions

3. Behavioral health & Substance Abuse: 30-Day Readmissions

RD-3. Potentially Preventable Complications (PPCs)
Hospital performing providers subject to required Category 4 reporting must report on the 64 PPC measures listed below in DY 4-5: #36 Acute Mental Health Changes

RD-4. Patient-centered Healthcare

1. Patient Satisfaction
2. Medication management

RD-5. Emergency Department
Admit decision time to ED departure time for admitted patients (NQF 0497)
a. Decision Time to transfer an emergency patient to another facility (not Transport Time), i.e. decision to make the first call from arrival in transferring ED until call initiated. Recommend threshold of < 1 hour for critical patient.

We expect our project, 137949705.2.1, to have a direct and significant positive impact on domains RD1, RD2 & RD5. Our project is a care coordination effort for patients who suffer from behavioral health conditions. Many of these patients visit our hospitals and emergency departments for acute and non-acute treatment. Our goal is to reduce admissions and readmissions for this target population through care management and helping these patients find appropriate primary behavioral health in an ambulatory care setting. Through these processes we expect to reduce the utilization of our emergency departments for such primary behavioral health services.
### Category 4: Population-Focused Measures

**The Methodist Hospital - 137949705**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Maximum Incentive Amount</td>
<td>$226,322</td>
<td>$</td>
<td>$90,529</td>
<td></td>
</tr>
</tbody>
</table>

#### Domain 1: Potentially Preventable Admissions (PPAs)

- **Planned Reporting Period:** 1 or 2
- **Domain 1 - Estimated Maximum Incentive Amount:**
  - Year 2: $226,322
  - Year 3: $ |
  - Year 4: $90,529
  - Year 5: $90,529

#### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

- **Planned Reporting Period:** 1 or 2
- **Domain 2 - Estimated Maximum Incentive Amount:**
  - Year 2: $90,529
  - Year 3: $90,529
  - Year 4: $90,529

#### Domain 3: Potentially Preventable Complications (PPCs)

- **Includes a list of 64 measures identified in the RHP Planning Protocol.**
- **Planned Reporting Period:** 1 or 2
- **Domain 3 - Estimated Maximum Incentive Amount:**
  - Year 2: $ |
  - Year 3: $90,529
  - Year 4: $90,529

#### Domain 4: Patient Centered Healthcare

**Patient Satisfaction - HCAHPS**

- **Measurement period for report:** January - December
- **Planned Reporting Period:** 1 or 2
  - Year 2: 2
  - Year 3: 2
  - Year 4: 2
  - Year 5: 2
## Medication Management

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>January - December</th>
<th>January - December</th>
<th>January - December</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Domain 4 - Estimated Maximum Incentive Amount</td>
<td>$90,529</td>
<td>$90,529</td>
<td>$90,529</td>
</tr>
</tbody>
</table>

## Domain 5: Emergency Department

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>January - December</th>
<th>January - December</th>
<th>January - December</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td>$90,529</td>
<td>$90,529</td>
<td>$90,529</td>
</tr>
</tbody>
</table>

## OPTIONAL Domain 6: Children and Adult Core Measures

### Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>January - December</th>
<th>January - December</th>
<th>January - December</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>January - December</th>
<th>January - December</th>
<th>January - December</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Domain 6 - Estimated Maximum Incentive Amount | $                  | -                  | $                  |

### Grand Total Payments Across Category 4

<table>
<thead>
<tr>
<th>Region 3</th>
<th>January - December</th>
<th>January - December</th>
<th>January - December</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Total Payments Across Category 4</td>
<td>226322 $</td>
<td>452,644 $</td>
<td>452,644 $</td>
</tr>
</tbody>
</table>

Regional Healthcare Partnership Plan

Region 3

2810
The Methodist Willowbrook
Performing Provider Name: Methodist Willowbrook Hospital

TPI: 140713201

Patient Data and Quality Reporting: Domains 1 - 5

The Methodist Hospital System (Methodist) has been proactive with regard to federal quality and data reporting requirements. Methodist also currently submits administrative, coded, de-identified data to Texas Health Care Information Collection (THCIC). Once HHSC determines the nature of the data to be reported and the technical specification for reporting, Methodist will develop the appropriate data reporting for Category 4 Domains 1 through 5 and respective measures.

Domain 1, 2, and 3 are based on 3M’s APR-DRGs. Methodist is in the process of implementing MIDAS, a software system that is a 3M partner and utilizes its reporting methodology. MIDAS is a staged implementation which is expected to be in place in 2Q 2013. The system covers Inpatient, Outpatient and Emergency Department patient visit details which are chained encounters.

Domain 4 contains two components: a) Patient-centered health care or patient satisfaction data and b) Medicaid Management. These are currently addressed by two separate reporting systems. Patient satisfaction measures are managed by Press Ganey, which utilizes a survey tool that includes the HCAHPS standard questions. The data is reported to CMS for use in Hospital Compare. Medication management is a functionality of MethOD, our electronic medical record (EMR). The EMR contains the following: home medication list, inpatient medication orders, home to inpatient reconciliation, patient transfer medication reconciliation, medication administration, patient refusal of medication administration, and discharge medication documentation. HHSC currently receives reports from providers in XML formats. Methodist has the capability to provide reports in XML. Once HHSC determines the specific data to be collected and reported, Methodist will evaluate the data capture reporting capability.

Domain 5 relates to Emergency Department admit to departure length of time. HHSC will need to determine whether the approach to this is a core measure approach or a patient management approach. In the event that HHSC seeks to capture core measurement information the MIDAS system discussed above would be expected to capture that information. If the data sought is strictly patient management aimed at arrival date/time and date/time of patient disposition then an ED management system, MedHost, could be utilized for the data collection and reporting.

Category 4 Valuation: Methodist will utilize the 10% valuation for Domains 1 – 5 with an equal spread between domains and measures.

Domain Descriptions: A description of how Category 4 measures relate to the project/outcomes.

Because the DSRP project submitted relates to Care Coordination for Behavioral Medicine patients seen in the Emergency Department, the following Category 4 Domains are specific to the project which Methodist will design and implement. Data will be collected, analyzed and interventions developed for care coordination to reduce admissions, readmissions, patient
satisfaction, medication management, complications, and emergency department patient management.

RD-1. Potentially Preventable Admissions

3. Behavioral Health and Substance Abuse Admission rate (based on other selected PPA primary diagnoses)

RD-2. 30-day Readmissions

3. Behavioral health & Substance Abuse: 30-Day Readmissions

RD-3. Potentially Preventable Complications (PPCs)
Hospital performing providers subject to required Category 4 reporting must report on the 64 PPC measures listed below in DY 4-5: #36 Acute Mental Health Changes

RD-4. Patient-centered Healthcare

1. Patient Satisfaction
2. Medication management

RD-5. Emergency Department
Admit decision time to ED departure time for admitted patients (NQF 0497)

a. Decision Time to transfer an emergency patient to another facility (not Transport Time), i.e. decision to make the first call from arrival in transferring ED until call initiated. Recommend threshold of < 1 hour for critical patient.

We expect our project 140713201.2.1, to have a direct and significant positive impact on domains RD1, RD2 & RD5. Our project is a care coordination effort for patients who suffer from behavioral health conditions. Many of these patients visit our hospitals and emergency departments for acute and non-acute treatment. Our goal is to reduce admissions and readmissions for this target population through care management and helping these patients find appropriate primary behavioral health in an ambulatory care setting. Through these processes we expect to reduce the utilization of our emergency departments for such primary behavioral health services.
### Category 4: Population-Focused Measures

**Methodist Willowbrook Hospital - 140713201**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Estimated Maximum Incentive Amount</strong></td>
<td>$33,262</td>
<td>$33,262</td>
<td>$33,262</td>
</tr>
</tbody>
</table>

#### Domain 1: Potentially Preventable Admissions (PPAs)

- **Planned Reporting Period:** 1 or 2
- **Domain 1 - Estimated Maximum Incentive Amount:** $33,262, $33,262, $33,262

#### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

- **Planned Reporting Period:** 1 or 2
- **Domain 2 - Estimated Maximum Incentive Amount:** $33,262, $33,262, $33,262

#### Domain 3: Potentially Preventable Complications (PPCs)

- **Planned Reporting Period:** 1 or 2
- **Domain 3 - Estimated Maximum Incentive Amount:** $33,262, $33,262

#### Domain 4: Patient Centered Healthcare

**Patient Satisfaction - HCAHPS**

- **Measurement period for report:** January - December
- **Planned Reporting Period:** 1 or 2, 1 or 2, 1 or 2
- **Domain 4 - Estimated Maximum Incentive Amount:** $33,262, $33,262, $33,262

**Medication Management**

- **Measurement period for report:** January - December
- **Planned Reporting Period:** 1 or 2, 1 or 2, 1 or 2
- **Domain 4 - Estimated Maximum Incentive Amount:** $33,262, $33,262, $33,262
### Domain 5: Emergency Department

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>January - December</th>
<th>January - December</th>
<th>January - December</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td>$33,262</td>
<td>$33,262</td>
<td>$33,262</td>
</tr>
</tbody>
</table>

### Optional Domain 6: Children and Adult Core Measures

<table>
<thead>
<tr>
<th>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)</th>
<th>January - December</th>
<th>January - December</th>
<th>January - December</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurement period for report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measurement period for report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain 6 - Estimated Maximum Incentive Amount</td>
<td>$</td>
<td>-</td>
<td>$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grand Total Payments Across Category 4</th>
<th>83155 $</th>
<th>166,311 $</th>
<th>166,311 $</th>
<th>166,311</th>
</tr>
</thead>
</table>

Regional Healthcare Partnership Plan
Region 3

Region 3

[242x547]January - December January - December January - December
[395x528]2 2 2
[309x499]$33,262 $33,262 $33,262
[401x306]$ -    $ -
[222x262]83155  $ 166,311  $ 166,311  $ 166,311
[40x504]Domain 5 - Estimated Maximum Incentive Amount
[40x495]Domain 6 - Estimated Maximum Incentive Amount
[40x481]Optional
[75x470]Domain 6 - Estimated Maximum Incentive Amount
[40x461]OPTIONAL Domain 6: Children and Adult Core Measures
[40x452]Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)
[40x443]Measurement period for report
[40x433]Planned Reporting Period: 1 or 2
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)
Measurement period for report
Planned Reporting Period: 1 or 2
Domain 6 - Estimated Maximum Incentive Amount
83155 $ 166,311 $ 166,311 $ 166,311

2815
Tomball Regional Hospital
Category 4 Population-Focused Improvements - Narrative Template

Performing Provider Name: Tomball Regional Medical Center (“Hospital”)
Performing Provider TPI #: 288523801

Domain 1: Potentially Preventable Admissions (2 measures)

- **Description** – Tomball Regional Medical Center will report on the 2 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions for COPD, flu and pneumonia, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. By increasing access to primary care for the indigent and uninsured, this project will improve the quality of health for this population by managing chronic conditions and preventing acute cases from escalating to the point of requiring hospital services.

- **Category 3 outcomes**: IT-2.5 Tomball Regional Medical Center goal is to reduce the COPD admission rates from 267, by 6 in DY 3, 12 in DY 4 and 15 in DY 5

- **Category 3 outcomes**: IT-2.10 Tomball Regional Medical Center goal is to reduce flu and pneumonia admissions from 594 in 2012 by 12 in DY 3, 24 in DY 4 and 30 in DY 5.

- **Valuation Rationale/Justification** – The value Tomball Regional Medical Center placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in at Hospital will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. Tomball Regional Medical Center values this reporting domain at $1,229,452 over Demonstration Years 3-5, requiring local funding of $494,351.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Tomball Regional Medical Center will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Tomball Regional Medical Center will work with the Indigent Clinic and provide access to medical specialists in order to establish follow-up protocols for the maintenance of chronic conditions, and thereby reduce the readmission rates for these services.

- **Category 3 outcomes**: IT-3.1 Tomball Regional Medical Center goal is to reduce the 30-day potentially preventable all-cause readmission rate from 13% currently to 10% by DY5

- **Valuation Rationale/Justification** - The value Tomball Regional Medical Center placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a
The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs for Hospital patients will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Tomball Regional Medical Center values this reporting domain at $1,229,452 over Demonstration Years 3-5, requiring local funding of $494,351.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Tomball Regional Medical Center will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and Hospital is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated.

- **Valuation Rationale/Justification** - The value Tomball Regional Medical Center placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital’s patients and the hospital’s operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Tomball Regional Medical Center values this reporting domain at $1,229,452 over Demonstration Years 3-5, requiring local funding of $494,351.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Tomball Regional Medical Center will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient’s willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. Hospital is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital’s providers need to engage in with patients to avoid readmissions, complications, and to promote improved health outcomes outside of the hospital setting. Tomball Regional Medical Center believes that with clinical protocols and discharge education, patients will receive proper follow-up care to improve their overall health and outcomes.

- **Valuation Rationale/Justification** - The value Tomball Regional Medical Center placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Hospital and how well Hospital performs its function of promoting medication management. Hospital is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease and lack of care coordination for traditionally underserved patients in Houston is costly to patients’ health and to the delivery system, and Hospital believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community. Tomball
Regional Medical Center values this reporting domain at $1,229,452 over Demonstration Years 3-5, requiring local funding of $494,351.

**Domain 5: Emergency Department (1 measure)**

- **Description** – Tomball Regional Medical Center will measure the ED visits quantities for the level I and II evaluation and management services for the defined patient population. This measure is important because patients often languish in hospital EDs due to lack of access to primary care in an outpatient setting. Reducing the unnecessary ED visits will improve the throughput of the more critically ill patients and thereby improve the health of the community served within the ED.

- **Valuation Rationale/Justification** - The value Tomball Regional Medical Center placed on this domain is based upon the value the Tomball Regional Medical Center attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Tomball Regional Medical Center values this reporting domain at $1,229,452 over Demonstration Years 3-5, requiring local funding of $494,351.

- **Category 1 or 2 expected patient benefits**: The project seeks to increase primary care clinic visits in DY4 by 1,300 and 1,339 in DY5.

- **Category 3 outcomes**: IT-9.2 Tomball Regional Medical Center goal is to reduce the ED utilization for the lower level acuity visits by 48 DY3, 96 DY4 and 120 DY5.
### Category 4: Population-Focused Measures

**Tomball Regional Medical Center / 288523801**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Estimated Maximum Incentive Amount</strong></td>
<td>Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</td>
<td>Milestone: Status report submitted to HHSC confirming system capability to report Domains 3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$</td>
<td>325,843</td>
<td>$</td>
<td>170,263</td>
<td></td>
</tr>
</tbody>
</table>

**Domain 1: Potentially Preventable Admissions (PPAs)**

**Planned Reporting Period: 1 or 2**

<table>
<thead>
<tr>
<th></th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1 - Estimated Maximum Incentive Amount</td>
<td>$</td>
<td>170,263</td>
<td>$</td>
<td>211,589</td>
</tr>
</tbody>
</table>

**Domain 2: Potentially Preventable Readmissions (30-day readmission rates)**

**Planned Reporting Period: 1 or 2**

<table>
<thead>
<tr>
<th></th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 2 - Estimated Maximum Incentive Amount</td>
<td>$</td>
<td>170,263</td>
<td>$</td>
<td>211,589</td>
</tr>
</tbody>
</table>

**Domain 3: Potentially Preventable Complications (PPCs)**

Includes a list of 64 measures identified in the RHP Planning Protocol.

**Planned Reporting Period: 1 or 2**

<table>
<thead>
<tr>
<th></th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 3 - Estimated Maximum Incentive Amount</td>
<td>$</td>
<td>170,263</td>
<td>$</td>
<td>211,589</td>
</tr>
</tbody>
</table>

**Domain 4: Patient Centered Healthcare**

*Patient Satisfaction - HCAHPS*
<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>10/1/13-9/30/14</th>
<th>10/1/14-9/30/15</th>
<th>10/1/15-9/30/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**Domain 4 - Estimated Maximum Incentive Amount**

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>10/1/13-9/30/14</th>
<th>10/1/14-9/30/15</th>
<th>10/1/15-9/30/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

| Domain 5 - Estimated Maximum Incentive Amount | $170,263 | $211,589 | $264,486 |

**Domain 5: Emergency Department**

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>10/1/13-9/30/14</th>
<th>10/1/14-9/30/15</th>
<th>10/1/15-9/30/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

| Domain 5 - Estimated Maximum Incentive Amount | $170,263 | $211,586 | $264,486 |

**OPTIONAL Domain 6: Children and Adult Core Measures**

**Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)**

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>n/a</th>
<th>n/a</th>
<th>n/a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

**Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)**

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>n/a</th>
<th>n/a</th>
<th>n/a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Domain 6 - Estimated Maximum Incentive Amount</td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Grand Total Payments Across Category 4</td>
<td>325,843</td>
<td>510,789</td>
<td>634,766</td>
</tr>
</tbody>
</table>
University of Texas-M.D Anderson
Category 4: Population-Focused Improvements (Hospitals only)

- The University of Texas MD Anderson Cancer Center / 112672402

- Domain Descriptions:
  - Domain 1: Potentially Preventable Admissions (8 measures)
    - Measures: Congestive Heart Failure Admission Rate; Diabetes Admission Rates; Behavioral Health and Substance Abuse Admission Rate; Chronic Obstructive Pulmonary Disease or Asthma Admission Rate; Hypertension Admission Rate; Pediatric Asthma; Bacterial Pneumonia Immunization; and Influenza Immunization
    - The five Category 2 DSRIP projects (112672402.2.1; 112672402.2.2; 112672402.2.3; 112672402.2.4; and 112672402.2.5) that we are submitting will all be implemented in a community setting. Our projects will have no impact on any of the Potentially Preventable Admissions in Reporting Domain 1 (RD-1). The intent of RD-1 is related to hospital admission and our projects are community-based. The only project that would have any connection to the measures (Influenza Immunization) is project # 112672402.2.1. It is a colorectal screening project is implemented with an influenza vaccination effort.
  - Reported: Calendar Year starting in DY3
  - Source: Texas Health and Human Services Commission, via risk adjusted 3M Tool

- Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)
  - Measures: Congestive Heart Failure (HF): 30-Day Readmissions; Diabetes: 30 Day-Readmissions; Behavioral health & Substance Abuse: 30-Day Readmissions; Chronic Obstructive Pulmonary Disease (COPD): 30-Day Readmissions; Stroke: 30-Day Readmissions; Pediatric Asthma: 30-Day Readmissions; and All-Cause: 30-Day Readmissions
    - The five Category 2 DSRIP projects (112672402.2.1; 112672402.2.2; 112672402.2.3; 112672402.2.4; and 112672402.2.5) that we are submitting will all be implemented in a community setting. These projects will have no impact on any of the Potentially Preventable Readmissions in Reporting Domain 2 (RD-2). The five Category 2 DSRIP projects (112672402.2.1; 112672402.2.2; 112672402.2.3; 112672402.2.4; and 112672402.2.5) that we are submitting will all be implemented in a community setting. They will have no impact on any of the Potentially Preventable Admissions in Reporting Domain 1 (RD-1).
  - Reported: Calendar Year starting in DY3
  - Source: Texas Health and Human Services Commission (HHSC), via risk adjusted 3M Tool
  - The University of Texas MD Anderson Cancer Center is a PPS-exempt cancer hospital and does not have to report on Potentially Preventable Readmissions. HHSC will identify exemptions for RDs 1-3 when making the data available to providers each DY.
○ **Domain 3: Potentially Preventable Complications (64 measures)**
  - The five Category 2 DSRIP projects (112672402.2.1; 112672402.2.2; 112672402.2.3; 112672402.2.4; and 112672402.2.5) that we are submitting will all be implemented in a community setting. The outcomes of those projects will have no impact on the 64 measures listed in Potentially Preventable Complications/Reporting Domain 3 (RD-3) as the 64 measures are related to hospital-based care/services.
  - Reported: Calendar Year starting in DY4
  - Source: Texas Health and Human Services Commission

○ **Domain 4: Patient-Centered Healthcare (2 measures)**
  - Patient satisfaction scores and Medication Management figures are monitored and are reported monthly as a deliverable on the Dash Board in Static.
  - Reported: 12-month periods for the following DYS:
    - DY3: 10/01/2013 to 09/30/2014
    - DY4: 10/01/2014 to 09/30/2015
    - DY5: 10/01/2015 to 09/30/2016
  - Source: The University of Texas MD Anderson Cancer Center
  - Measures:
    - **Patient Satisfaction** – The reporting of the measures must be limited to the inpatient setting only.
    - **Medication Management** – The reporting of the measures must be limited to the inpatient setting only. Two measures will be reported by PPs required to report Medication Reconciliation Metric (Medication reconciliation levels in discharged inpatient population derived from NQF 0646).
  - Projects’ Relationship to Domain 4 Measures:
    - Our five Category 2 projects (112672402.2.1; 112672402.2.2; 112672402.2.3; 112672402.2.4; and 112672402.2.5) will not be implemented in an inpatient setting. Since both measures of Domain 4 are specific to inpatient settings, none of our five Category 2 projects will have a direct impact on Patient Satisfaction or Medication Management.

○ **Domain 5: Emergency Department (1 measure)**
  - The number of patients who come to The University of Texas MD Anderson Cancer Center’s emergency room that require transfer to another institution is negligible and are not large enough to produce statistically valid data.
  - Reported: 12-month periods for the following DYS:
    - DY3: 10/01/2013 to 09/30/2014
    - DY4: 10/01/2014 to 09/30/2015
    - DY5: 10/01/2015 to 09/30/2016
  - Source: The University of Texas MD Anderson Cancer Center
• **Domain Valuation:**
  The percent allocation for Category 4 was distributed evenly across the all of the reporting measures for each DY. Whereas, the University of Texas MD Anderson Cancer Center is exempt from Domain 2, the percent allocation for each DY has been distributed evenly among the remaining four Domains and their corresponding Milestones and Reporting Domains as applicable.
### Category 4: Population-Focused Measures

*The University of Texas MD Anderson Cancer Center / 112672402*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone: Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Maximum Incentive Amount</td>
<td>$595,074.47</td>
<td>$454,513.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Domain 1: Potentially Preventable Admissions (PPAs)

<table>
<thead>
<tr>
<th>Domain 1 - Estimated Maximum Incentive Amount</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>EXEMPT</td>
<td>EXEMPT</td>
<td>EXEMPT</td>
<td>EXEMPT</td>
</tr>
<tr>
<td>Domain 1 - Estimated Maximum Incentive Amount</td>
<td>$454,513.00</td>
<td>$453,418</td>
<td>$555,878</td>
<td></td>
</tr>
</tbody>
</table>

#### Domain 2: Potentially Preventable Readmissions (30-day readmission rates)

<table>
<thead>
<tr>
<th>Domain 2 - Estimated Maximum Incentive Amount</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>EXEMPT</td>
<td>EXEMPT</td>
<td>EXEMPT</td>
<td>EXEMPT</td>
</tr>
<tr>
<td>Domain 2 - Estimated Maximum Incentive Amount</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain 2 - Estimated Maximum Incentive Amount</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Domain 3: Potentially Preventable Complications (PPCs)

Includes a list of 64 measures identified in the RHP Planning Protocol.

<table>
<thead>
<tr>
<th>Domain 3 - Estimated Maximum Incentive Amount</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>EXEMPT</td>
<td>EXEMPT</td>
<td>EXEMPT</td>
<td>EXEMPT</td>
</tr>
<tr>
<td>Domain 3 - Estimated Maximum Incentive Amount</td>
<td>$453,418</td>
<td></td>
<td>$555,878</td>
<td></td>
</tr>
</tbody>
</table>

#### Domain 4: Patient Centered Healthcare

**Patient Satisfaction – HCAHPS**

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>10/01/2013 to 09/30/2014</td>
<td>10/01/2014 to 09/30/2015</td>
<td>10/01/2015 to 09/30/2016</td>
<td></td>
</tr>
<tr>
<td>Medication Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measurement period for report</td>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
<td>Year 5</td>
</tr>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>10/01/2013 to 09/30/2014</td>
<td>10/01/2014 to 09/30/2015</td>
<td>10/01/2015 to 09/30/2016</td>
<td></td>
</tr>
<tr>
<td>Domain 4 - Estimated Maximum Incentive Amount</td>
<td>EXEMPT</td>
<td>EXEMPT</td>
<td>EXEMPT</td>
<td>EXEMPT</td>
</tr>
<tr>
<td>Domain 4 - Estimated Maximum Incentive Amount</td>
<td>$454,513.00</td>
<td>$453,418</td>
<td>$555,878</td>
<td></td>
</tr>
</tbody>
</table>

#### Domain 5: Emergency Department

<table>
<thead>
<tr>
<th>Measurement period for report</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>10/01/2013 to 09/30/2014</td>
<td>10/01/2014 to 09/30/2015</td>
<td>10/01/2015 to 09/30/2016</td>
<td></td>
</tr>
<tr>
<td>Domain 5 - Estimated Maximum Incentive Amount</td>
<td>09/30/2015</td>
<td>09/30/2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------</td>
<td>------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Reporting Period: 1 or 2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain 6 - Estimated Maximum Incentive Amount</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OPTIONAL Domain 6: Children and Adult Core Measures**

- **Frequency of ongoing prenatal care**
  - Measurement period for report
  - Planned Reporting Period: 1 or 2

- **Timeliness of prenatal care**
  - Measurement period for report
  - Planned Reporting Period: 1 or 2

- **Cesarean rate for low-risk first birth women**
  - Measurement period for report
  - Planned Reporting Period: 1 or 2

- **Percent of live births weighing <2500 grams**
  - Measurement period for report
  - Planned Reporting Period: 1 or 2

- **Pediatric central-line associated bloodstream infection (CLASBI) rates**
  - Measurement period for report
  - Planned Reporting Period: 1 or 2

- **Elective delivery prior to 39 weeks completed gestation**
  - Measurement period for report
  - Planned Reporting Period: 1 or 2

- **Appropriate use of antenatal steroids**
  - Measurement period for report
  - Planned Reporting Period: 1 or 2

- **Postpartum Care Rate**
  - Measurement period for report
  - Planned Reporting Period: 1 or 2

- **Domain 6 - Estimated Maximum Incentive Amount**
  - n/a
  - n/a
  - n/a
  - n/a

**Grand Total Payments Across Category 4**

<table>
<thead>
<tr>
<th>09/30/2015</th>
<th>09/30/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>$595,074.47</td>
<td>$1,818,051</td>
</tr>
<tr>
<td>$1,813,673</td>
<td>$2,223,513</td>
</tr>
</tbody>
</table>
Section VI RHP Participation
Certifications
Section VII Addendums

A. Hospital Certifications
B. Indigent Care Agreements
C. Projects Not Selected Summary
D. Collaboration Letters
E. Letters of Support
F. Additional Information